

REPRODUCTIVE RAINBOW: EXPLORING FERTILITY INTENTIONS AND FAMILY
PLANNING EXPERIENCES WITHIN THE 2SLGBTQ COMMUNITY

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By

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Abstract

Background: Normative beliefs around gender and sexuality place individuals in the Two Spirit, lesbian, gay, bisexual, trans, and queer (2SLGBTQ) community at risk for poorer health outcomes within the healthcare system compared with heterosexual and cisgender counterparts. Accessing healthcare in highly gender-specific areas – such as family planning and fertility intentions – can be particularly challenging for those within the 2SLGBTQ community.

Methods: I used Stake's case study methodology and arts-based research with a social-ecological model and intersectionality framework to explore experiences fertility intentions and family planning. Virtually, I retrieved data from reddit and completed nine in-depth semi-structured interviews with eleven participants. **Results:** Participants, with a mean age of 24.6, represented diversity in their genders and sexualities. In the imagining phase, ideals of normal, lived experiences and intersections of identities form the fertility intentions. When participants moved towards actioning fertility intentions, they experienced nuanced suppressive and supportive factors. Suppressive factors included financial, biological, and societal, while supportive factors were community. Factors that were both supportive and suppressive included family, seeking information and healthcare systems. **Conclusion:** Intersectionality allows further exploration of the effect that heteronormativity, cisnormativity and other aspects of identities like race, culture, and age overlap and interlock to create variations in ideals of normal, lived experience and suppressive factors. As nurses, moral and ethical responsibility is to use our privileged position within society to advocate for safe and inclusive nursing education, practice, and spaces for our patients. Nurses can call for action at the individual, community, and institutional levels.

Land Acknowledgement

I conceptualized this thesis on Treaty 6 territory - the ancestral and traditional territory of the Cree, Dene, Blackfoot, Saulteaux, Nakota Sioux, and the homeland of the Métis. I wrote this thesis on Treaty 6 territory, Treaty 7 territory - the traditional territories of the Blackfoot Nations, including Siksika, Piikani, and Kainai, the Tsuut'ina Nation and Stoney Nakoda First Nations – and Treaty 1 territory – the homeland of the Metis. Many of the thoughts, concept and ideas within this thesis came to me while I was outside in nature, feeling connected to the Earth. We are all treaty people. Through acknowledging the land, my ancestors before me, and those who protect the land, I aim to continually build respectful and reciprocal relationships with all things. I will do this by continuing to engage with learning through Indigenous art, literature, and ways of knowing, by listening to voices of the Indigenous community, and supporting Land Back movements.

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List of Abbreviations

2SLGBTQ	Two spirit, lesbian, gay, bisexual, transgender, queer
ABR	Arts-based research
CHNC	Community Health Nurses of Canada
DSM	Diagnostic and Statistical Manual
GD	Gender dysphoria
HCP	Health care provider
SEM	Social ecological model
WPATH	World Professional Association for Transgender Health

Chapter I – Framing the Issue

Normative beliefs around gender and sexuality place individuals in the Two Spirit, lesbian, gay, bisexual, trans, and queer (2SLGBTQ) community at risk for poorer health outcomes within the healthcare system when compared with their heterosexual and cisgender counterparts (Brotman et al., 2002; Fredericks et al., 2017; Richardson et al., 2019). These normative beliefs are due to the gender binary, a dominant cultural ideology and practice held within Western society, that views only two genders based on sex and places men and women in a categorical oppositional hierarchy (Beasley, 2005). This hierarchy then privileges men and perpetuates heteronormativity and cisnormativity. Heteronormativity includes the belief that being heterosexual is the most desirable and normal identity (Beagan et al., 2012). Cisnormativity includes the belief that the most normal identity is one's assigned sex at birth (James-Abra et al., 2015).

As dominant societal beliefs, both heteronormativity and cisnormativity create barriers for the 2SLGBTQ community (Lim & Hsu, 2016). These barriers extend into accessing and receiving healthcare services (Elertson & McNiel, 2020). Considering the healthcare system is a significant structure within Western society, healthcare policies may influence societal perceptions of what is normal. Additionally - and vice versa - societal perceptions of the norm may shift what people in the healthcare system consider normal. Ultimately, there is a fixation on sameness or difference in society, which does not create space for anything outside of a binary (van Anders, 2015).

Within healthcare, heteronormativity and cisnormativity - shown in part through healthcare provider (HCP) bias and non-inclusive language, forms and policies - contribute to further discrimination, poorer health outcomes, and increased marginalization of those within the

2SLGBTQ community (Fredericks et al., 2017; Richardson et al., 2019; Searle et al., 2017; Utamsingh et al., 2016). Even though many of the general healthcare needs of the 2SLGBTQ community are no different than those who identify as heterosexual or cisgender (Manzer et al., 2018), in highly gendered areas – as with family planning and fertility intentions – the 2SLGBTQ community may face additional barriers (Klein, Malcolm, et al., 2018; Richardson et al., 2019).

Problem Statement

Due to heteronormative and cisnormative bias within the healthcare system, members of the 2SLGBTQ community may face additional barriers and oppressions when accessing healthcare services in highly gendered areas – specifically when exploring fertility intentions and family planning.

Research Question

Considering that healthcare operates within a heteronormative and cisnormative society, and individuals conceptualize families in many ways, how do members of the 2SLGBTQ community experience family planning and fertility intentions, and how can nurses support 2SLGBTQ community members throughout these experiences?

Aim and Purpose

With this research, I aim to explore the fertility intentions and family planning experiences of individuals within the 2SLGBTQ community to understand how to best support their decisions. The purpose of this research is to explore the effect that heteronormativity and cisnormativity have on the experiences of the 2SLGBTQ community and to learn how healthcare needs can be met in an appropriate, safe, holistic, and comprehensive manner.

Terms and Concepts

For this research, fertility intention includes the plan to have – or not have – children (Vignoli & Rinesi, 2014). Family planning is planning the number and timing of births and can include contraceptives, abortion, and fertility testing and treatments (Canada Public Health Association, n.d). The acronym *2SLGBTQ* is an umbrella term that includes multiple sexualities and genders. I will use this acronym throughout the research to refer to any participant who self identifies as such. As language is continually changing and evolving, there is a chance that this acronym may not be fully reflective of all sexualities and genders.

Additionally, the acronym may incidentally group complex individual identities and does not infer that the experiences of all those within the 2SLGBTQ community are the same. I chose to use the 2SLGBTQ acronym as it is regional and representative of Saskatoon's community, which places Two Spirit and Indigenous Peoples at the forefront (OUTSaskatoon, 2020a). Of note, for clarity, when referring to previous research, I continue to use the acronym 2SLGBTQ.

The following is a list of terms and definitions that refer to specific sections of the 2SLGBTQ community. Unless otherwise noted, all terms are from OUTSaskatoon (2020a).

Asexual	<p>A person who experiences little to no sexual attraction or desire to others.</p> <p>Asexuality can be viewed on a spectrum and can range from someone who is in a fulfilling romantic relationship that involves sex, but may not require or desire it, to a person who does not have sex. Asexuality is different from celibacy and abstinence, as celibacy and abstinence are a choice.</p>
Bisexual	<p>A person attracted to two (or more) genders. Some bisexual people define their identity as being attracted to women and men, while others may define their identity as being attracted to their own and other genders.</p>

Cisgender	A person whose gender is the same as the gender assigned at birth
Gay	A person attracted to people of the same gender.
Intersex	“Intersex is a variation in sex characteristics including chromosomes, gonads, or genitals that do not allow an individual to be distinctly identified as male or female” (OK2BEME, 2019, para 11).
Lesbian	A person (woman or non-binary) exclusively attracted to women.
Non-Binary	A person whose gender exists outside of, or between, the gender binary. The term can be used solely to describe one’s gender, and it can also be used as an umbrella term for all identities that exist outside of the binary of woman and man (i.e., agender, genderqueer, bigender, non-binary, gender fluid, etc.).
Pansexual	A person who is attracted to people regardless of their gender.
Queer	An umbrella term to refer to the entire 2SLGBTQ community
Transgender	A person whose gender is different from the gender assigned at birth
Two Spirit	An Indigenous person who holds unique gendered roles within the Indigenous worldview of gender, which is separate from the Eurocentric gender binary. In contemporary understandings of Two Spirit, this can also include sexual/romantic orientations. The term Two Spirit is a pan-Indigenous term that acknowledges the historical acceptance of gender and sexual diversity prior to colonization. This term speaks specifically to the experiences of Indigenous peoples and the disruption of historical acceptance towards diversity.

Background and Significance

Healthcare Challenges

Within the healthcare system, it is common for members of the 2SLGBTQ community to feel unheard, unsafe, and uncomfortable in most interactions with their providers. Many individuals have been denied access to healthcare, been discriminated against, experienced stigmatization, and reported negative experiences when working with a variety of healthcare providers in a variety of settings (Brotman et al., 2002; Fredericks et al., 2017; Klein, Berry-Bibee, et al., 2018; Klein, Malcolm, et al., 2018; Lindroth, 2016; Richardson et al., 2019; Tornello et al., 2019). Those within the 2SLGBTQ community are at higher risks of multiple health concerns when compared to the heterosexual and cisgender community (Lim et al., 2014). The health concerns range across the life span and can be both specific to individual groups and shared across the community. For example, lesbians are more likely to be overweight or obese and have a higher likelihood of fatal breast cancer than heterosexual, cisgender women (Lim et al., 2014). Men who have sex with men are more likely to be diagnosed with HIV, human papillomavirus and anal cancer (Lim et al., 2014). Health concerns across the 2SLGBTQ community include heart disease, asthma, eating disorders, alcohol consumption, substance abuse, suicidal ideation, suicide attempts, and partner violence (Lim et al., 2014).

Considering the barriers that the 2SLGBTQ community faces within general healthcare environments, arguably additional barriers exist in areas that are highly gendered. For example, cervical cancer rates are similar between transmen and ciswomen, however multiple barriers - including knowledge at the individual and healthcare provider (HCP) level – mean that transmen are less likely to be screened for cervical cancer (Dhillon et al., 2020). Furthermore, related to sexual and reproductive health, 2SLGBTQ clients have specific needs (Klein, Malcolm, et al.,

2018), and - specific to fertility intentions and family planning - report concerns that include a lack of provider knowledge, empathy, and awareness; safe spaces; and forms and handouts that are gender and sexually inclusive (Klein, Berry-Bibee, et al., 2018; Klein, Malcolm, et al., 2018).

Healthcare Provider Beliefs

Cause and Effect

Everyday discourse perpetuates heteronormativity through media, education, and healthcare literature by maintaining the belief that normal is a man and a woman in an opposite-sex relationship (Eliason & Chinn, 2018; Plummer, 1984). Additionally, because of differences in cultural beliefs, stigmatization of the 2SLGBTQ community occurs, leading to sexuality being politicized, and non-procreative sex having less value than procreation (Plummer, 1984). The notion that non-procreative sex is less valuable than procreative sex may contribute to the belief system, ethical challenges, and biases among some HCP when treating members of the 2SLGBTQ community related to fertility intentions and family planning.

Fallacy of Equality

Many HCPs believe that to treat everyone equally, they must treat everyone the same (Beagan et al., 2012; Dorsen & Van Devanter, 2016; Manzer et al., 2018; Rider et al., 2019; Stewart & O'Reilly, 2017). Related to gender and sexuality, HCPs report they simply avoid discussing the topics as not to 'offend' their patients (Rider et al., 2019). Because of heteronormativity and cisnormativity, a lack of acknowledgment - or remaining neutral - assumes everyone is heterosexual and cisgender (Fredericks et al., 2017). Therefore, ignoring one's gender and sexuality perpetuates normative beliefs and discrimination and can inadvertently render the 2SLGBTQ community invisible (Dorsen & Van Devanter, 2016; Eliason et al., 2010; Lindroth, 2016; Stewart & O'Reilly, 2017). These invisibilities, or lack of

acknowledging one's whole identity, may cause additional barriers for the 2SLGBTQ community when accessing healthcare services.

Trans Challenges

There may also be increased barriers for specific members of the 2SLGBTQ community. For example, trans individuals report facing the most challenges when accessing healthcare services (Clark et al., 2018; Lindroth, 2016), and HCPs often direct queerphobia at trans individuals (Stewart & O'Reilly, 2017). This phobia causes nurses to feel the least comfortable working with trans patients compared with others in the 2SLGBTQ community, which can create additional barriers in accessing appropriate services (Manzer et al., 2018). At an institutional level, a systematic review shows that many educational curricula for HCPs excluded trans health topics, and studies addressing HCP attitudes towards the 2SLGBTQ community, did not address HCPs opinions of trans patients (Sekoni et al., 2017). These findings show transphobia within the healthcare system, cisnormative privileging, a lack of understanding and trans invisibility. Patients explained that when HCPs do something as seemingly simple as acknowledging pronouns, gender, and sexual orientation, they create a safe and inclusive space, fostering better relationships with HCPs and the healthcare system (Brown et al., 2019; Eisenberg et al., 2020).

Missed Opportunities in Healthcare

When accessing healthcare services, concerns from the 2SLGBTQ community indicate that clinical practices lacked gender neutrality, were based on heteronormativity (Klein, Berry-Bibee, et al., 2018), and lacked cultural sensitivity (Klein, Malcolm, et al., 2018). Interestingly, both HCPs and the 2SLGBTQ community noticed overlapping lacking areas. To begin, HCPs recognized they lacked education, experience, and resources to provide culturally competent care to the 2SLGBTQ community (Angelino et al., 2020; Elertson & McNiel, 2020; Manzer et al.,

2018; Richardson et al., 2019; Rider et al., 2019). Similarly, 2SLGBTQ patients accessing healthcare services also recognized that HCPs lacked the knowledge to treat them holistically and appropriately (Clark et al., 2018; Lindroth, 2016). Furthermore, a lack of relevant clinical training caused HCPs to report that they often relied on their 2SLGBTQ patients to teach them about gender diversity and sexual health (Manzer et al., 2018). Members of the 2SLGBTQ community also reported having to teach HCPs about their gender or sexuality (Fredericks et al., 2017; James-Abra et al., 2015). From this, both members of the 2SLGBTQ community (Eisenberg et al., 2020; Snyder et al., 2017) and HCPs (Angelino et al., 2020; Elertson & McNiel, 2020) agreed that education programs related to gender and sexuality for HCPs are paramount. With the interventions that exist, very few actively involved members of the 2SLGBTQ community in program development and delivery (Eisenberg et al., 2020; Morris et al., 2019; Sekoni et al., 2017). Again, the lack of 2SLGBTQ voices is pertinent, as many HCPs felt that hearing the real-life experiences of 2SLGBTQ people were the most poignant part of their education (Elertson & McNiel, 2020; Morris et al., 2019). Ultimately, these deficiencies pose a problem where 1) both provider and patient feel as though they are unable to help or be helped, 2) both parties know the HCPs lack education, but neither knows what to do about it, and 3) if HCPs receive education, it lacks input from the 2SLGBTQ community, even though that is what may be the most effective when educating HCPs. These intersecting insufficiencies effectively create gaps that fail to comprehensively and confidently address the 2SLGBTQ community's needs.

Creating Conditions for Visibility

Representation provides a way for individuals to situate themselves in the outside world and make meaning of their identities (Reed, 2018). Although visibility and representation for the

2SLGBTQ community is increasing, challenges exist as diverse representations that are wholly representative are lacking (Reed, 2018). Ultimately, there are missed opportunities that may render the 2SLGBTQ community invisible. However, shifts may be happening to make the community more visible. For example, the 2021 long-form Canadian census will - for the first time - include in-depth questions on sex and gender (Statistics Canada, 2019), which will provide Canadian citizens, government and policymakers data from this population that has previously been excluded. Additionally, in 2017, the Canadian government invested 650 million dollars over three years towards improving reproductive health for at-risk populations, including the 2SLGBTQ community (Government of Canada, 2019). Considering the links between policy and healthcare, if governments, healthcare systems and policymakers acknowledge and make the 2SLGBTQ community visible, then HCP may value the difference in the experiences of those within the 2SLGBTQ community.

Visibility of Families

Based on cultural norms and societal understandings, the term ‘family’ can encompass many different definitions. Historically, scholars have understood families as two individuals – husband and wife – married under the law and sharing a common residence and parenthood duties (Weigel, 2008). Scholars have often used parenthood or reproduction at the centre of the definition of what makes a family (Weigel, 2008). Among 2SLGBTQ families, intersectional representation is lacking (Reed, 2018), as most research focuses on White¹ gay and lesbian parents (Goldberg & Sweeney, 2019). Additionally, some members of the 2SLGBTQ community may experience challenges in starting a family because of societal stigmas and lack

¹ Please note choosing to capitalize the 'w' in White came with much reading and reflection. I have chosen this because when I capitalize White, I acknowledge that Whiteness functions within our structures and systems. It creates accountability to acknowledge how Whiteness exists, privileges and is an identity in itself. White should not be neutral, and by giving capitalizing the word, I aim to create accountability for the impact of Whiteness.

of community knowledge (Goldberg & Sweeney, 2019). Lack of representation further reinforces the invisibilities that members of the 2SLGBTQ community feel based off of dominant societal beliefs and cultural narratives (Reed, 2018). Increasing representation for and hearing the stories of 2SLGBTQ families can shift the idea of what we believe to be normal, allowing these understandings to shift (Newman, 2019). For the purpose of this research, family is fluid, socially constructed and varies from person to person (Weigel, 2008).

Visibility in Research

Despite the societal increase in visibility among the 2SLGBTQ community, both general research (Waite & Denier, 2019) and research specific to family planning and fertility intentions for the 2SLGBTQ community is lacking (Klein, Berry-Bibee, et al., 2018). For example, researchers acknowledge the lack of research related to bisexual (Manning et al., 2014; Short et al., 2007), gender variant (Hafford-Letchfield et al., 2019), and trans parents (Hafford-Letchfield et al., 2019; Short et al., 2007), as well as general input from 2SLGBTQ individuals (Wingo et al., 2018). Engaging the 2SLGBTQ community in research to understand the barriers they face to accessing services was highlighted as important research moving forward (Klein, Berry-Bibee, et al., 2018; Wingo et al., 2018). It is imperative to include the unheard voices within the 2SLGBTQ community to explore the community's health needs fully.

Significance to Nursing

Compared with other healthcare disciplines, nursing has remained mostly silent around political aspects of health (Weitzel et al., 2020). Related to the 2SLGBTQ community, this silence may be due in part to a universal classification of skills that perpetuate sameness among patients and promote 'gender-neutral' nursing practices (Eliason et al., 2010), and the belief that nurses must treat everyone equally *regardless* of their gender identity and sexual orientation

(Beagan et al., 2012). This neutrality relates to the Community Health Nurses of Canada (CHNC) (2020) standard of health equity; if we treat everyone the same, we unintentionally silence people, render some identities invisible, and lack acknowledging that the 2SLGBTQ community faces discrimination, marginalization, and poor health outcomes as a result of the healthcare system.

Considering that nursing often focuses on individual risk factors, awareness of the systemic exclusion of the 2SLGBTQ community from healthcare and nursing education may be lacking (Eliason et al., 2010). Because of nursing's responsibility toward social justice, nurses must acknowledge the challenges faced by members of the 2SLGBTQ community when accessing healthcare, educate themselves, and advocate for better patient care (Eliason et al., 2012). Nursing's emancipatory way of knowing encourages nurses to advocate for changes within the system to allow for all voices to be heard and represented appropriately, leading to health equity for the 2SLGBTQ community (Peart & Mackinnon, 2018).

Nursing is a highly gendered practice within the patriarchal, heteronormative, and cisnormative society and healthcare system (Eliason, 2017). As such, nurses may be a part of the current problem and a part of the solution. Considering that the healthcare system creates a power divide between those who are different, vulnerable or marginalized (Van Herk et al., 2011), nurses must be aware of imbalances to then mitigate and challenge barriers. As nurses, we have an opportunity to create safe, open spaces that are inclusive and healing. Something as simple as asking pronouns or providing multiple genders on forms can benefit those fitting outside of heteronormativity and cisnormativity (Brown et al., 2019). The task of normalizing asking, and then acknowledging and using proper pronouns in interactions can help create a

therapeutic relationship, allowing individuals to feel supported and less stress when accessing services (Brown et al., 2019).

Nurses can challenge the normative nature of current healthcare practices by discussing the need for diversity and culturally appropriate nursing care, and advocate for more inclusive spaces to validate patient existence and experiences (Searle et al., 2017). In order to challenge the systems, nurses must acknowledge the role that heteronormativity and cisnormativity play within our practice. By acknowledging this, nurses then begin understanding the importance of recognizing the specific health needs of the 2SLGBTQ community. The information obtained from this research can enable nurses to build capacity when working with the 2SLGBTQ community in many gendered and non-gendered settings.

Summary

The gender binary perpetuates heteronormativity and cisnormativity. These normative beliefs create barriers and oppress members of the 2SLGBTQ community within society and the healthcare system, especially in highly gendered areas, such as fertility intentions and family planning. There is a current lack of representation of the 2SLGBTQ community in healthcare education and research, which warrants further exploration to maximize this population's inclusion and health potential. HCPs acknowledge links are missing to provide the best care for the 2SLGBTQ community. Nursing as a discipline has – deliberately or not – taken on the mentality that we must treat everyone the same, which - when based in heteronormative and cisnormative spaces - assumes heterosexuality and cisgender identities are *neutral* and *normal*.

With this research, I aim to explore the experiences of family planning and fertility intentions within the 2SLGBTQ community, and the potential impact that heteronormativity and cisnormativity have on experiences and decisions. The next section will review the literature and

explore the effects that historical, societal and interpersonal beliefs have on the fertility intentions and family planning experiences of the 2SLGBTQ community.

Chapter II – Literature Review

I used a social-ecological model (SEM) to frame the literature review, which assumes that many intersecting and related factors affect health (Betker et al., 2015). SEM provides the opportunity to disentangle the historical, societal, familial and individual spheres of influence when used to explore the impact that heteronormativity and cisnormativity may have on fertility intentions and family planning experiences within the 2SLGBTQ community:

1. I explore the broad historical factors that affect how society views sex and gender,
2. I discuss societal structures and the impact they have on dictating and policing choices,
3. I explore the role that family and friends play in influencing decisions, and
4. I explore the impact that history, societal structures and family roles have on an individual's decision-making process.

Historical Influences

One-Sex, Two-Sex

Some sources believe that during the Pre-Enlightenment era, society understood there to be only one sex (Laqueur, 1992). The one-sex model viewed male and female reproductive anatomy as the same, except that female anatomy was considered inferior and internal (Laqueur, 1992). This inferiority is exemplified by the belief that the vagina was an inferior internal penis, and the ovaries were inferior internal testes (Laqueur, 1992). Ultimately, women were viewed - simply - as lesser men (Laqueur, 1992). In the Eighteenth Century (around the Enlightenment era), based on a shift in political and cultural beliefs and philosophical thinking patterns, the two-sex model (gender binary) became the dominant view (Laqueur, 1992). The gender binary views men and women as biologically and socially different and creates prescribed identities for each of the sexes (Laqueur, 1992).

Furthermore, these created categories (male and female) are seen in opposition to one another – the opposite sex. For example, to be a male (i.e., have a penis and be masculine) is not to be a female (i.e., to have a vagina and be feminine) (Beasley, 2005; Prasad, 2005). In the late 19th century, biologists claimed that - at a cellular level - women were more passive and stable, and men were more active and passionate (Geddes, 1889 as cited in Laqueur, 1992). These identities solidified specific roles that men and women must fulfill. Traditionally, society expected men to perform roles in the public sphere, and expected women to fill roles in the private or domestic sphere (Beasley, 2005).

Based on biological facts driven by the medical system, the gender binary has been the dominant Western view of sex and gender (Laqueur, 1992). This view was encapsulated and solidified by prominent laws summarized and published in 1967 by sociologist Harold Garfinkel (Prasad, 2005). These laws viewed everyone as one of two genders (and being abnormal if you were not) and defined gender as a permanent, lifelong, continuum with nature creating and assigning gender based on one's genitals (Prasad, 2005). These laws conflate gender and sex, and - along with social practice and expectations - create categories into which one must fit (Prasad, 2005). Effectively, the gender binary dictates the societal understandings of sex and gender, ultimately affecting men and women's political, economic, and cultural roles (Laqueur, 1992).

Reproduction and the Binary

Historically, fertility and birth rates were crucial aspects in regulating the population; thus, considering heterosexual reproductive potential, these identities were considered more valuable (Foucault, 1978). Within this context, the couples that bear the most children are the most valued and thus seen as the foundation of the family and society (Warner, 1991).

Considering that Canada did not legalize same-sex marriage until 2005 (Rau, 2019), it is clear many inequities still exist for societal validation of 2SLGBTQ marriages, let alone the validity of 2SLGBTQ parents. Although there are possibilities for those within the 2SLGBTQ community to reproduce and become parents, society believes that heterosexual and monogamous couples are the “gold standard” for parents (Hicks, 2006). These beliefs consider anyone outside of the gender binary to be, first, devalued based on their reproductive capacity, and second, devalued as parents. We can then conclude that the most valued couples within the gender binary are married, heterosexual, monogamous, non-disabled, arguably White, and willing and able to reproduce.

Diagnostic Power

The healthcare system holds power to create diagnoses and categories for those who fit inside of the gender binary and those who do not. These categories and differences can lead to vulnerabilities, marginalization, and poorer healthcare experiences and outcomes for those outside of the binary (Van Herk et al., 2011). Until 1973, being gay was considered a diagnosable mental illness (Ard & Makadon, 2016; Brotman et al., 2002; Standing Committee on Health, 2019), and it was not until 1987 that it was removed from the Diagnostic Statistical Manual (DSM) (Brotman et al., 2002). When one receives a medical diagnosis, there is a belief that one needs to be treated or cured. For those who identified as gay, the treatment took place through inhumane methods of conversion therapy, aversion therapy and electroshock therapies (Brotman et al., 2002).

People who are intersex (born with ambiguous genitalia) provide an example that reinforces the power the healthcare system has in dictating what is normal. In the 1950s, HCPs based the ‘treatment’ of intersex infants on which genital assignment made the most surgical

sense (Fausto-Sterling, 2000; Hird, 2000). Following surgery, families raised the infant based on their corresponding gender (Fausto-Sterling, 2000; Hird, 2000). Patriarchally, if a HCP assigned an infant's sex as female, the primary surgical requirement for a vagina was to ensure it could accommodate a penis (Hird, 2000). The medical community then deemed surgical interventions successful when the treated person aged within their assigned gender and married the opposite sex (Fausto-Sterling, 2000). These medical practices highlight the preference for heterosexual and cisgender identities that can sexually perform for the purpose of reproduction. These practices police and control the experiences that 2SLGBTQ individuals have, given the barriers faced within our current society. In these scenarios, HCPs act as gatekeepers in dictating what is “best” and “normal.” This maintains that HCPs and the healthcare system are all-knowing and in control of deciding one's identity.

Impacts of Colonization

Beginning to understand historical trauma can help explain colonization's impact on Indigenous people (Weitzel et al., 2020). Society has not appropriately addressed the long-lasting health and social effects that colonization has on Indigenous Peoples, especially those within the 2SLGBTQ community (Ristock et al., 2019). The term Two Spirit acts as an umbrella term and is pan-Indigenous across Turtle Island (Hunt, 2016). Two Spirit may refer to an individual, spiritual, and cultural identity broader than the Western understanding of gender, sex, and sexuality (Hunt, 2016). Considering an Indigenous worldview does not incorporate the gender binary, one's identity as Two Spirit can be related to one's gender, sex and roles in the community (Hunt, 2016; OUTSaskatoon, 2020b). Before the first contact, Two Spirit people were well-respected individuals that had unique gifts to offer their communities (OUTSaskatoon, 2020b; Ristock et al., 2019). A goal of colonization – through residential schools – was to

eradicate all Two Spirit identities, culture, teachings, and ways of life (Angelino et al., 2020; Ristock et al., 2019). This goal was based on beliefs held by the Christian religion at that time that were deeply homophobic, transphobic and rooted within the gender binary (Ristock et al., 2019). These beliefs also relied on heteronormative and cisnormative marriage ideals and forced Indigenous peoples into colonial relationships to obtain rights and status (Hunt, 2016). The goals of this cultural genocide were achieved by disrupting Indigenous culture, language, land rights, and political structures within their societies (Hunt, 2016). Because of colonization's long-lasting effects, Indigenous People face multiple health inequities and experience higher rates of substance use, lower socioeconomic status (Hunt, 2016), and higher rates of interpersonal and systemic violence when compared with their settler counterparts (Ristock et al., 2019).

Intersections and Invisibilities

The Two Spirit community is rendered invisible due to heteronormative, cisnormative, and racist beliefs within structural settings (Hunt, 2016). Members of the Two Spirit community may also face discrimination, homophobia, and transphobia within their Indigenous communities (Hunt, 2016; Standing Committee on Health, 2019). The Two Spirit community lacks representation within both 2SLGBTQ and Indigenous health literature (Hunt, 2016), likely due to cisnormativity, heteronormativity, and racism within structural settings (Angelino et al., 2020). From what we know, members of the Two Spirit community face additional challenges when accessing healthcare and other social services, such as drop-in centers and counselling programs (Hunt, 2016). Furthermore, the Two Spirit community experiences high rates of suicide (Issa, 2019; National Aboriginal Health Organization, 2012; Wechsler, 2016), high rates of substance use (Hunt, 2016; Issa, 2019), and high rates of violence (Hunt, 2016; Ristock et al., 2019; Scheim et al., 2013). However, current research involving the Two Spirit community is

significantly lacking (Lyons et al., 2016; Scheim et al., 2013; Waite et al., 2019). To the best of my knowledge, no one has completed research involving the Two Spirit community related to fertility intentions and family planning.

Societal Structures

Healthcare System

Due to the gender binary's impact through discourse and discipline, the healthcare system dictates what knowledge is essential. Colloquially, society believes that knowledge is power. This sentiment is especially true within the healthcare system; knowledge is power, and discourse holds power (Holmes & Gagnon, 2018). Linking knowledge, discourse, and power, the healthcare system dictates what is essential knowledge and holds power to determine what discourse – and in turn, identity – is most valued.

HIV/AIDS Epidemic

Members of the 2SLGBTQ have experienced blatant discrimination at the hands of society and the healthcare system. The HIV/AIDS epidemic exemplifies this and led many gay men to believe their health concerns were not valid and that the healthcare system was ignoring their needs during a critical time (Rau, 2019). Although healthcare and society know more about HIV/AIDS, the healthcare system further reinforces stigma and negative perceptions around being a member of the 2SLGBTQ community. For example, the Canadian Blood Services (n.d) policy requiring men who have sex with men to abstain from sexual contact for three months before donating blood reinforces stigma. However, 2018 Canadian statistics indicated that 34% of all new HIV diagnoses were of those having heterosexual sex (Challacombe, 2020). The restriction on men who have sex with men may appear to some as a preventative measure but is discriminatory and fraught with assumptions.

Additionally, based on historical and present situations, the 2SLGBTQ community may not trust disclosing their full identities and may not trust HCPs to provide appropriate and respectful care (Brotman et al., 2002). These beliefs could contribute to the current reinforcement of heteronormativity and cisnormativity and perpetuate homophobia and transphobia within healthcare (Brotman et al., 2002).

Heteronormative Privileging

Examples of the power the healthcare system has over the 2SLGBTQ community are also shown by disallowing many same-sex visitations when their partner is in the hospital, a privilege held by many heterosexual couples (Fileff, 2012). Although laws exist to protect those in the 2SLGBTQ community to visit their partners while in hospital, some reported being treated differently and being subject to a long line of questions regarding their relationship status (Parker-Pope, 2009). Some 2SLGBTQ couples report having more success when telling HCPs they are siblings versus partners (Parker-Pope, 2009). With that, 2SLGBTQ populations are othered by society and within healthcare. Like knowledge and discourse, othering can be used as a form of power and may shift depending on social, political or external factors (Canales, 2010).

Furthermore, some couples expressed HCPs ignored their trans identities when seeking care for reproduction. For example, a lesbian couple - where one partner was trans - was encouraged by HCPs to have intercourse instead of using a sperm donor (James-Abra et al., 2015). The couple felt as though HCPs did not acknowledge their true identities, and they were only seen as a product of their reproductive parts (James-Abra et al., 2015). As well, before adoption became legal for people in same-sex relationships, being a gay man meant that you would not become a parent unless you were in a heterosexual relationship (Berkowitz, 2011).

These examples show the heteronormative and cisnormative privileging and the inability of some HCPs to acknowledge one's full identity as valuable.

Diagnostic Power Revisited

Until the mid-20th century, a transgender person was often diagnosed as psychopathological or a sexual deviant (Drescher et al., 2012). In the 1960s, the first gender identity clinics for adults were established in North America, and by the 1980s there were enough information around transgender people that a diagnostic criteria was proposed (Drescher et al., 2012). In the most recent edition of the DSM-5, terminology around the diagnosis changed from a being a 'gender identity disorder' to 'gender dysphoria' to be less stigmatizing (American Psychiatric Association, 2013). The DSM-5 lists Gender Dysphoria (GD) as an incongruence between one's assigned and experienced gender (American Psychiatric Association, 2013). Previous to this, GD was pathologized, debated, and transition was highly criticized by physicians and psychiatrists (Drescher et al., 2012). Additionally, the new changes in the DSM-5 separates GD from sexual dysfunction and paraphilic disorders, and has been placed in its own chapter (American Psychiatric Association, 2013). This language change and movement away from sexual pathologizing may highlight the shift of healthcare systems to more inclusive models of diagnosis and delivery related to identities existing outside of the binary. The most recent Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People encourage the supports for trans individuals to be flexible and patient-centred (World Professional Association for Transgender Health [WPATH], 2011). The standards also discuss how gender-diverse identities are not pathological or harmful, and each individual will require a unique set of treatment and support (WPATH, 2011). The standards also

discuss that it is not gender-diverse people who are disordered and need treatment, but the dysphoria they experience (WPATH, 2011).

Although the DSM-5 and the WPATH standards of care both state that gender nonconformity is not a mental disorder (American Psychiatric Association, 2013; WPATH, 2011), HCPs may still act as gatekeepers to specific services based on their practices and beliefs (Dorsen & Van Devanter, 2016). This gatekeeping could influence the treatment that a trans person is offered and received, as is the desired treatment, it may not be easy to access. There are laws in certain countries requiring sterilization before gender reassignment surgery can occur (von Doussa et al., 2015). These laws reinforce the belief that sexes are opposite, and to be one, you cannot be the other. It also enhances the power that the healthcare system has in gatekeeping who may be ‘deserving’ of treatment, which may force one to fit into a specific box to be valid and worthy enough to prescribe transition treatments (Lindroth, 2016).

Additionally, HCPs may consider providing reproductive care to the 2SLGBTQ community as an ethical dilemma based on religious beliefs and concerns for potential children (Klein, Berry-Bibee, et al., 2018).

More Trans Challenges

Members of the healthcare system decide who gets to be a parent or not by supporting or opposing reproductive choices for members of the 2SLGBTQ community (Klein, Berry-Bibee, et al., 2018). Specific to trans parents, these considerations parallel the societal beliefs that they are unfit for parenthood, ultimately dictating one's reproductive choices (James-Abra et al., 2015; Tornello & Bos, 2017). Furthermore, many trans people are not given any information regarding their reproductive options before, during, or after the transition, leaving them unaware of their fertility potential should they choose to have children (Tornello & Bos, 2017; von Doussa et al.,

2015). Specifically, before the transition, trans people may not be given the option to cryopreserve their gametes (von Doussa et al., 2015), directly impacting their ability even to make a reproductive choice.

Following the transition, some believe they are infertile when they may not be, and others reported being unaware of their fertility options when taking hormone therapy (Tornello & Bos, 2017). These examples within the trans community show the privileging of heteronormative and cisnormative options for reproducing and the additional barriers trans people may face. By choosing which information to provide to their patients, the healthcare system and HCPs – whether intentionally or not - continue to hold power to other those they consider to be different.

Societal Beliefs

Gender norms maintained by the gender binary create five main barriers for members of the 2SLGBTQ community that parent outside of the norm. First, some believe that 2SLGBTQ people should not become parents because it is morally wrong and damaging to children (Hicks, 2006). Second, there is a societal fear that gay parents could make gay children and that gay men are perverts (Hicks, 2006). Third, the stereotype exists that if gay men want to have children, they must be effeminate (Hicks, 2006). Fourth, because of the gender norms that view women as being caregivers, gay men are seen as less-desirable parents and, in turn, less desirable options for adoption agencies (Berkowitz, 2011). Lastly, there are deep-seated Western cultural concerns about the ability and capacity for trans people to be parents (von Doussa et al., 2015).

The discussion surrounding Thomas Beatie, a transman who became pregnant, highlight societal concerns regarding trans people's ability to parent. In the media, commentators stated that he gave up his right to carry a pregnancy when he “decided” to be a man (von Doussa et al., 2015). Despite these societal concerns, compared to heterosexual parents, lesbian and gay

parents are more child-focused and have more equality in the household division of labour (Short et al., 2007). Both traits are associated with more positive outcomes for the child (Short et al., 2007). Of note, most research related to the well-being of children of same-sex parents is based on lesbian mother families (Manning et al., 2014). This example shows the societal privileging of some 2SLGBTQ identities over others and may show bias in the policing of knowledge related to the 2SLGBTQ community. I argue that these privileges, societal beliefs and expected gender roles create a hierarchy of 2SLGBTQ parents. Within this hierarchy, lesbian women are the most desirable *other* parent option, followed by gay men, plurisexual people and, trans folks.

Some members of the 2SLGBTQ community felt that HCPs viewed their primary purpose as procreation (Wingo et al., 2018). For example, 2SLGBTQ women reported that if they told HCPs they were not interested in procreating, the HCP would not acknowledge *any* of their reproductive health concerns as valid (Wingo et al., 2018). This choice shows that fertility intentions differ from person to person, and support will be necessary regardless of choice (von Doussa et al., 2015; Wingo et al., 2018). These reports may also reinforce the binary ideals that a woman's purpose is to bear children and that the most valued position in society is to be monogamous, married and reproducing - ultimately further reinforcing the categories of the gender binary.

Intersections

Gender, sexuality, race, and class intersect to devalue identities and create barriers for the reproductive choices of the 2SLGBTQ community in four main areas. First, the cost of fertility treatment may create additional barriers due to gay and gender pay gaps. Depending on one's desires, ability, and accessibility, surrogacy, adoption and fertility treatment may be financially straining (Tornello & Bos, 2017). Second, if a couple decides to adopt, class and race privilege

the adoption processes (Berkowitz, 2011). Unfortunately, there are additional challenges for people of colour who wish to adopt, considering White privilege, lower pay grade and an expensive process (Berkowitz, 2011). Third, due to lower socioeconomic status and cultural power, when compared with White men, Black and Latino gay men may face more difficulties in the adoption process (Berkowitz, 2011). Additionally, within the adoption system, White and non-disabled children often are considered more desirable (Berkowitz, 2011). In turn, the adoption process values race, income, and ability and views 2SLGBTQ, Black, Indigenous and people of colour as less desirable parents, which often means that 'less desirable' parents have a difficult time matching with 'desirable' children (Berkowitz, 2011).

Related to financial barriers, income levels are challenging to interpret, as many factors influence income, including relationship status, education level and location (Denier & Waite, 2019). Generally, gay men have a lower income than heterosexual men (who earn the most), lesbians have a higher income than heterosexual women, and bisexual individuals make less than heterosexual men and women (Denier & Waite, 2019). The trans pay gap may be the most significant (Nath, 2018). Within trans individuals' intersections, trans men are eventually paid higher post-transition, where trans women, on average, lose one-third of their income (Connell, 2012). Furthermore, the trans community experiences three times higher levels of unemployment than the general population and trans communities of colour these levels are four times higher than the general population (National Center for Transgender Equality, 2016). Income levels are significant as fertility treatments can be expensive, and no 2SLGBTQ funding exists in Canada (Rainbow Health Ontario, 2014).

Legalities

Legal barriers exist along with financial and social barriers. For families that choose to use donor gametes, there may be a general lack of legal protection and the potential for legal complications (Tornello & Bos, 2017). The potential complications create an additional barrier, where some families expressed not wanting to take a legal risk in using donor gametes (Tornello & Bos, 2017). While legal barriers may be improving for same-sex families, donor gametes can be challenging to navigate legally.

Family or Friend Influences

Social factors influence what one believes to be normal (Hammack et al., 2019). These social factors then influence how one experiences the world and how one society expects one to be (Hammack et al., 2019). Specific to fertility intentions, trans individuals report that having children through intercourse was expected from family or friends regardless of gender (Tornello & Bos, 2017). Trans individuals also mention that family and friends would ask when they were having kids and make statements that noticed they were good with kids (von Doussa et al., 2015). Moreover, as related to societal expectations for those existing outside of the norm, when conceptualizing a family, some trans individuals felt that having children was a societal expectation and expressed feeling pressure from their families and friends to have children (Tornello & Bos, 2017). Interestingly, those who reported these expectations were in relationships, potentially reinforcing the idea that society values reproduction by people who are monogamous and married.

Individual Thoughts and Beliefs

The individual choices made by the 2SLGBTQ community related to fertility intentions and family planning can be linked to the maintenance of the norm. For example, trans

individuals who chose to have children stated an average desire to have two children, similar to the average family size in Canada and the United States (Tornello & Bos, 2017). Specific to the trans population, common themes to having children include the desire to be biologically related to them, wanting to give back to kids in need (if adopting or fostering), and based on personal expectations of always wanting to be a parent (Tornello & Bos, 2017). Some participants explore that they always hoped to have children, which had always been part of their narrative (von Doussa et al., 2015). In contrast, others were unsure if they foresaw having kids, either biologically or adopted (von Doussa et al., 2015).

Participants discussed barriers to reproduction as the financial cost of fertility treatments or the adoption process, lack of information around reproductive potential, and complex individual beliefs around normative meanings of ‘mother’ and ‘father’ (Tornello & Bos, 2017; von Doussa et al., 2015). Additionally, participants discussed the emotional aspect of the unknown with stopping hormone replacement therapies, and for transmen that could carry a pregnancy - not wanting to change physically and psychologically based on their current hormone regime (Tornello & Bos, 2017).

Given the dominance of the gender binary and heteronormative and cisnormative privileging, parenting examples outside of the norm are often not shown. In discussing the plan to become parents, members of the 2SLGBTQ community identified a lack of 2SLGBTQ specific parenting resources as a barrier for understanding their own options (Ellis et al., 2015; Wingo et al., 2018). Similarly, if gay men chose to adopt, there was a lack of information. Unless they found others who knew the experience, they did not know where to turn to for help, leaving them feeling confused and powerless (Berkowitz, 2011). In the same way, a common theme noted a lack of sharing of information of how other 2SLGBTQ individuals conceptualize having

a family, or how to achieve their family, and some individuals wanting to connect with 2SLGBTQ people through the different stages of pregnancy, as they often reported feeling alone (Ellis et al., 2015; Wingo et al., 2018). Additionally, if members of the 2SLGBTQ community are interested in becoming parents, some studies reported that over half of HCPs showed some discrimination towards this community when providing services to become parents (Klein, Berry-Bibee, et al., 2018). Again, this shows the power the healthcare system holds in policing the reproductive choices of those that do not fit within the norm.

Summary

Historical understandings of sex and gender, based within the gender binary create restrictive gendered categories for everyone to fit within. These categories create societal and political identities that hold specific expectations of how one must be. All individuals' societal roles influence the understanding of what is most normal and right when related to reproduction. Historically, society has valued reproduction because of a need to increase the population making those with greatest reproductive capacity the most valued (Foucault, 1978; Hicks, 2006; Warner, 1991). Society and healthcare place more value on heterosexual, married, monogamous, and procreative sex practices, creating a hierarchy. Thus, these hierarchies create and maintain barriers and oppression that privileging some identities while devaluing others (Hammack et al., 2019). Because of these privileges, heterosexual and cisgender identities are the most valued parents. The intersections of class, race, gender, and ability further oppress those fitting outside of the binary. The healthcare system 1) perpetuates heteronormativity and cisnormativity; 2) holds power in dictating who is the most normal and valued identity, and 3) privilege some over others. The historical and societal factors influence one's family and friends' opinions, which ultimately trickle down and affect an individual's beliefs. These beliefs further highlight how

societal norms shape those outside of heteronormativity and cisnormativity by the predominant hierarchy of what it means to be normal. In the next section, I will discuss the methodology, frameworks, and methods used to collect and analyze data.

Chapter III - Methods

For this research, my specific objectives were to 1) understand the beliefs and factors that influence family planning and fertility intentions within the 2SLGBTQ community; 2) understand the experience of the 2SLGBTQ community accessing healthcare related to family planning and fertility intentions; and 3) explore the ways to support the 2SLGBTQ community about family planning and fertility intentions.

Positionality

I come to this research as a cisgender, non-disabled, White settler, upper-middle-class, English speaking, female, with educational funding. Because of these attributes, I fit into certain categories where I am privileged and thus hold power. The privilege that I hold can influence my data collection and analysis and I, therefore, worked directly with Jack Saddleback and engaged in every learning opportunity regarding the 2SLGBTQ community that I could. This provided space for dialogue and thoughtful introspection of my place as a researcher.

Through this research, I have also reflected on my own fertility intentions. As a single woman in her early thirties with work experience at a fertility clinic, I am bordering on being past my 'prime fertility' and do not have definitive fertility intentions. The parts of my identity noted above affect how I come to the research and analyze and interpret the results. This research has challenged my perceptions of heteronormativity and cisnormativity. I hope to continue to challenge the beliefs of those that exist within similar situations as my own. Engagement with community partners encourages power balance and ensures each research step is with the community's best interest in mind. Throughout data collection, analysis, and knowledge translation, I aim to amplify the voices of the 2SLGBTQ community.

Social Context

This research is framed by national and international societal events that contribute to data collection and analysis. The COVID-19 pandemic², the murder of George Floyd³ and the Black Lives Matter movement's resurgence⁴, high number of trans people being killed internationally and nationally⁵, and the 2020 US presidential election⁶ highlighted racial, sexual and gender disparities affecting all aspects of health. Considering both the social-ecological model and intersectionality, it is important to draw attention to the broader social context as it may influence participant responses and data analysis.

Conceptual Framework

Intersectionality and SEM

Scholars use intersectionality as a lens to examine the overlap of oppressions or inequalities that an individual or group may face (Winker & Degele, 2011). The use of intersectionality as a theoretical framework allows for the investigation of how privilege and systems of oppression may overlap with the 2SLGBTQ community's experiences related to fertility intentions and family planning (Few-Demo, 2014). Researchers must consider oppression, privilege and their related forms of opportunity and conflict that change the social context of how individuals and groups interact within society (Few-Demo, 2014). Considering my positionality, it is important to examine the effects that power and oppression have on fertility intentions and family planning for the 2SLGBTQ community. From a nursing profession perspective, an intersectionality framework allows nurses to more deeply understand issues of

² <https://www.yesmagazine.org/health-happiness/2020/06/09/coronavirus-public-health-social-justice/>

³ <https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html>

⁴ <https://www.theguardian.com/commentisfree/2020/jun/30/black-lives-matter-protests-voting-policy-change>

⁵ <https://www.them.us/story/at-least-350-transgender-people-killed-globally-in-2020>

⁶ <https://www.theguardian.com/australia-news/audio/2020/nov/03/us-election-2020-trump-and-the-rise-of-white-supremacist-extremism>

oppression and privilege and how we can incorporate this as a social justice mentality within our profession (Van Herk et al., 2011). Social justice is a broad theory focusing on creating equitable and fair societies for all individuals by redistributing power and resources (Canadian Nurses Association [CNA], 2009). In their concept analysis, Buettner-Schmidt and Lobo (2012) defined social justice as “full participation in society and the balancing of benefits and burdens by all citizens, resulting in equitable living and a just ordering of society” (p. 954). Furthermore, the World Health Organization (2021) defines equity as the absence of avoidable differences among groups of people (para 1). As intersectionality allows an in-depth exploration of oppressions and privileges, it parallels with social justice, aiming to create equity among all groups and individuals. An intersectionality framework offers guidance that can improve individual practice and broader professional areas such as nursing education, research, and policy (Van Herk et al., 2011). Because all policies are health policies (World Health Organization, n.d), it is essential that nurses understand the impact that policy can have on the health of individuals and populations. Scholars that use the lens of intersectionality also value the lived experiences of individuals, giving voice to those that have previously been silenced (Hankivsky et al., 2017). Using this framework, my goal is to create awareness and discussion around the impact that structures of oppressions have on identities when exploring fertility intentions and family planning with the 2SLGBTQ community. When using a framework of intersectionality, I also acknowledge the intricacies and layers to one’s identity and the complexities that exist within. As such, solutions will be nuanced and complex as power is multidimensional. For example, nurses have power to provide or withhold care, but may lack power within the medical hierarchy. The use of SEM alongside intersectionality allows for a deeper understanding of the historical,

societal, familial and individual factors that may interplay in creating barriers and oppressions to affect one's health and the nursing profession (Betker et al., 2015).

Methodology

Case Study

As the experience of family planning and fertility intentions within the 2SLGBTQ community may vary greatly depending on one's gender and sexual identity, case study methodology, as described by Stake, allows for an in-depth exploration of an individual's experience within their specific context (Baxter & Jack, 2008; Miles & Huberman, 1994). This research aims to give voice to the 2SLGBTQ community, explore their experiences, and understand a social phenomenon, which aligns closely with case study methodology (Richards & Morse, 2013). Case study is often used to answer 'how' and 'why' questions within a specific context and understand the connections between the context and the phenomenon (Baxter & Jack, 2008). Stake offers a flexible approach to case study, focusing on the case and *what* is studied, versus the method of *how* it is studied (Harrison et al., 2017). Stake (1995) also acknowledges that many research topics are entangled within historical, social, and individual perspectives, which links this methodology both to SEM and intersectionality. Assessment of a single case for this research allows for in-depth exploration of the case from the perspective of a variety of individuals, including those in different roles, groups, cultures, and organizations, known as "within case sampling" (Miles & Huberman, 1994, p. 29). Within case sampling considers cases to be nested and incorporates the broader, social and political context of the case (Miles & Huberman, 1994), furthermore aligning with SEM and intersectionality. Additionally, population sampling is theoretically driven, and understanding the concept occurs from multiple

perspectives (Miles & Huberman, 1994). The use of multiple data sources ensures the exploration of the research question through more than one lens (Baxter & Jack, 2008).

Stake (1995) operates from a constructivist epistemology and believes that reality has multiple meanings based on individuals' interpretation (Harrison et al., 2017). Stake's (1995) constructivism centers the researcher as an interpreter and acknowledges that - as knowledge is constructed based on our realities - each researcher will bring a unique perspective to the case. The 2SLGBTQ participants make up a single case that is bound by time and the aim to tell a collective story of their experiences of family planning and fertility intentions. Stake's (1995) case study is well suited for this research, as experiences may be quite varied depending on one's identity, and the fundamental goal of case study is to analyze multiple perspectives and seek understanding to best understand the issue (Harrison et al., 2017). As well, considering the flexibility both within Stake's approach, and case study in general – this methodology arguably bodes well for a complex topic that researchers have understudied, including general research on the 2SLGBTQ community. With case study, data is often derived from multiple means, for example news articles or relevant policies (Miles & Huberman, 1994). Sampling data from several sources may also create space to value perspectives outside of academia and begin to decolonize knowledge.

Study Design

Location

Due to the COVID-19 pandemic, interviews were completed virtually through WebEx, a secure digital communication platform. The virtual nature of the interviews allowed for no geographical boundaries for participants.

Participants

The study population included those self-identifying within the 2SLGBTQ community. Inclusion criteria was child-free, English-speaking individuals between the ages of 16-45 years of age. To ensure I collected Two Spirit data appropriately and holistically, Jack Saddleback acted as a community advisor. I completed purposive and snowball sampling with the help Jack Saddleback recruiting specific to Two Spirit individuals. I recruited through the University of Saskatchewan via PAWS (an internal message board) and through posters placed at OUTSaskatoon and OUTSaskatoon's social media platform. Most interview participants were recruited via PAWS – the University of Saskatchewan's internal announcement server, which lead to most participants being students. See Appendix A for demographic sheet given to participants.

Data Collection

Data collection occurred from October 2020 – January 2021 via semi structured interviews and data from reddit.

reddit

reddit is an online community where users can submit any content to the platform. The content is further divided by *subreddits* –groups of content focused on a specific topic (Anderson, 2015). The content on reddit is supplied by its users, and is open to anyone – with or without an account (Anderson, 2015). In order to post and create content – one must register to become a 'redditor' (Anderson, 2015). Registration takes place by creating a username or pseudonym, which are (mostly) anonymous and have the option to not be linked to an email account (Anderson, 2015). As of January 2020, reddit boasted over 52 million daily active users in over 100,000 communities (reddit, 2021). I chose to explore the conversations that were had in

two subreddits - /r/queerception, and /r/seahorse_dads. Queerception is labeled as “a support community for LGBTQ folks growing their families” and has 5300 members (reddit, 2016, para 1). Seahorse_dads is “a safe space for trans men with biological children, whether you're trying, expecting, had an accidental pregnancy, or have already had your children” and has 456 members at the time this was written (reddit, 2019). As reddit uses pseudonyms it was not possible to gain demographic data from the users.

I collected data from reddit by searching the top posts within the subreddits. From there, I read the top posts, the questions posed and the replies from the members of the community. Posts ranged from gender-neutral or non-conforming parent related names to be called, to the effects that internalized homophobia has on parenting. From reviewing the conversations, I compiled data from the topics that paralleled or added to what the interview participants had said.

In-depth Semi-Structured Interviews

I used a semi-structured interview guide to conduct the interviews (Appendix B). Interviews lasted on average one hour and six minutes. The interview guide was informed by a review of the literature and the interview flow was guided by Mayan (2009) who wrote about the five stages of an interview (introducing self and topic, asking easy questions, asking more sensitive questions, returning to easy questions, closing interview).

Art-Based Research

Developed as a marriage between social sciences and the arts, ABR is closely linked with qualitative research and uses art to deepen further our understanding of human experience (Savin-Baden & Wimpenny, 2014). This method allows those involved to understand the world and make meaning through the artistic process (Savin-Baden & Wimpenny, 2014; Wang et al., 2017). ABR aligns with Stake's (1995) constructivist worldview (Savin-Baden & Wimpenny,

2014). When used, ABR is thought to draw attention to complexities within a concept and create questions that can help further discussion, and build community through engaging a diverse range of community members (Wang et al., 2017). Collage making creates meaning through contrasting mediums, thus evoking emotion and discussion when the elements are taken out of context (Savin-Baden & Wimpenny, 2014). ABR's view for this study is *arts in research* (Wang et al., 2017), and *arts-informed inquiry* (Savin-Baden & Wimpenny, 2014), which is applied when researchers are involved in creation of the artistic process. In these views, arts is used to aid in the analysis phase of research, and make findings accessible (Savin-Baden & Wimpenny, 2014). ABR allows the engagement of those involved to make meaning of experiences through the art process (Savin-Baden & Wimpenny, 2014). ABR in data analysis draws attention to societal complexities that can understand and explore deeper meanings (Wang et al., 2017). Furthermore, ABR can supplement exclusively academic text enabling individuals outside of academia to be aware of research findings (Wang et al., 2017).

The initial intent was to do collage creation with a small group of participants to inform the interview questions for the individual interviews. Due to limited in-person engagement with participants due to the COVID-19 pandemic I was unable to do this. Following multiple conversations with my supervisor and committee we decided that instead my supervisor, my community advisor and I would complete the collages together but appropriately distanced. Unfortunately, due to timing and COVID-19 based restrictions, we were unable to complete this as well. This led to me engaging in collage creation independently to assist in analysis and forming the discussion. Although there was variation from the initial intent, it aligned with making findings more accessible and drew attention to the complex nature of the topic.

Ethical Considerations

I obtained ethics from the University of Saskatchewan Research Ethics Board BEH #1862 before participant recruitment. Adbusters and Shameless magazines granted copyright approval (Appendix C) for all print media used in collage making. REB deemed data from reddit exempt from ethics approval as it is an anonymous online platform where information is readily and publicly available.

Jack Saddleback was engaged in the project as a community advisor based on his lived experience as a gay, trans, Two Spirit man and his relationship with the Two Spirit community.

Rigor

Within qualitative research, rigor is a broad and debated concept that has been broken down and defined into many terms (Mayan, 2009). Based on Mayan's (2009) interpretations, my conceptualization of rigor involves being reliable, credible, and considerate, and producing findings that are just. Because of my positionality within this research, I involved Jack Saddleback as a community advisor. Additionally, I took every opportunity to learn more about the 2SLGBTQ community from the 2SLGBTQ community. When collecting data, I continually challenged any assumptions, questioned the obvious, kept memos, had multiple discussions with my supervisor, and coded data as soon as interviews were transcribed (Richards & Morse, 2013). Stake (1995) discussed consequential validity, in that the researcher, given their interpretations of the data, must be prepared for the consequences of the information derived from the data. Member checking also provided a further avenue to ensure rigor.

Member Checking

Engaging in reflexivity, understanding community practices, and colloquial language are essential steps I took in maintaining and establishing effective relationships. The use of member

checking ensures the accuracy of participant's voices and maintains accountability with my representation and description of a potentially vulnerable population to avoid further marginalization (Stake, 1995). After I transcribed the individual interviews and completed the first stage of data analysis, I sent a summary of the key themes to each participant to review and provide feedback. All participants responded and were in agreeance of the themes.

In reflection, I am unsure if this puts additional strain on the participants, or if the inherent power imbalance between researcher and participant makes it challenging for participants to correct what the researcher has said. Out of the eight member checks that I sent out, I had two participants engage further, one clarifying a theme I had identified, and the second participant added additional information they wanted to share.

Data Analysis

I recorded the interviews electronically and transcribed them verbatim before analysis began. To organize analysis, I uploaded the transcribed files into NVivo and inductively coded the transcripts. I engaged in reflective thematic analysis using Braun and Clarke (2006, 2020) six phase approach.

Reflexive Thematic Analysis

I chose to use reflexive thematic analysis as thematic analysis is accessible for beginner researchers and does not require extensive knowledge of theoretical methodologies (Braun & Clarke, 2006). Braun and Clarke (2020) clarified their approach from *thematic analysis*, defining it as *reflexive thematic analysis* that further emphasizes the subjectiveness of the researcher to be a resource for analysis. Thematic analysis aligns with Stake's perspective as it examines that ways in which events, realities, meanings, and experiences are the effects of a range of discourses operating within society (Braun & Clarke, 2006).

Phase one of analysis is becoming familiar with data, often done by transcribing and reading the transcripts (Braun & Clarke, 2006). I began phase one of analysis by transcribing all interviews within 24 hours of completion. After initial transcription, I would review the transcripts with spell check, and lastly, I would re-listen to the interview and update with any changes. I did not include any “ums”, “likes” or stutters that did not seem significant, or if participants stumbled over their words trying to construct a sentence. I did transcribe laughs and long pauses – which could have been influenced by the virtual connection. Following each interview, I wrote a memo as a summary of anything that I thought of afterwards or anything that appeared significant. Within 72 hours I sent the participants a summary of themes from the interview, allowing for time for their reflection on the conversation, but soon enough to not be forgotten.

Phase two of analysis – “generating initial codes” - involved working through the entire data set, noticing anything of interest, and coding as many potential themes and patterns as possible (Braun & Clarke, 2006, p. 88). Phase three – “searching for themes” – involves refining the list of codes from phase two looking at common themes or connecting factors (Braun & Clarke, 2006, p. 89). Braun and Clarke (2020) describe themes as stories that researchers tell based on patterns identified in the data that have shared meaning. As I progressed through phase three, I began to draw concept maps, connecting the themes to each other, noticing how interconnected and entangled all the themes were within each other. Phase four – “reviewing themes” – is re-reading and refining all of the codes and interviews, leading to re-organizing structures (Braun & Clarke, 2006, p. 91). Here, I continued to identify links between themes and began to notice things that were concrete or abstract. I also refined some of the coding names. I started to focus in on how entangled many of the themes were – for example, the links between

invisibility, representation, and emotional labour; and related to personal impacts on fertility intentions that community and family experience influenced personal impacts, which then influenced experiences with mental health.

Phase five – “defining and naming themes” – involves clearly defining themes, finding links between each theme and noting if there are any sub themes, to see how each theme fits within and tells a story (Braun & Clarke, 2006, p. 92). I started this theme in NVivo and then moved to more physical space, writing out themes on coloured paper and laying out connections between them. I also completed many mind maps looking at the connections between the themes. Phase six – “producing the report” – is just that, telling the story of data via this thesis (Braun & Clarke, 2006, p. 93). In producing the thesis, I often went back and forth between visual mapping and writing the analysis, as well as I engaged in conversations with my supervisor.

Summary

This study is based on the conceptual frameworks of intersectionality and SEM to understand the impact that multiple oppressions, historical events, society, and community can have on the individual experience. I completed interviews and collected data from reddit with 11 participants coming from diverse cultures, sexualities, genders, and relationships. Due to pandemic constraints, I did not complete Arts-Based focus groups. I completed data analysis and identified themes through use of Braun and Clarke’s (2006; 2020) reflexive thematic analysis and personal ARB.

Chapter IV – Results

I recruited a total of 11 individuals that participated in this study and completed nine in-depth semi-structured interviews, seven with individuals and two group interviews with different couples. Interviews lasted on average one hour and six minutes. Six participants were in relationships with other participants (three couples, two of which I interviewed together). Participants lived in two provinces in Canada (Ontario and Saskatchewan) and consisted of various genders, sexualities, relationship statuses and ethnicities. I collected data from two subreddits on reddit and a variety of users. Demographic data were not available from reddit users. Participants were given the option to use their name, choose a pseudonym, or contribute anonymously. See table 1 for patient demographics.

Table 4.1 Demographics

Age	Range 18-31; Mean 24.6	
Ethnicity	White	7
	European	1
	Asian	1
	First Nations	1
	Indigenous	1
Relationship status	Married	4
	Single	4
	Common Law	1
	In relationship	2
Gender*	Male	5
	Female	4
	Non-Binary	2
	Two Spirit	1
Sexuality	Gay	4
	Queer	4
	Lesbian	2
	Pansexual	1
Occupation⁺	Undergraduate Student	5
	Graduate student	1
	Chef	1
	Social Worker	1
	Registered Nurse	1
	Family MD	1
	Animator	1
	Youth Worker	1
	Waiter	1

* Some participants identified as multiple genders

⁺ some participants listed more than one occupation

Two participants identified as trans, one trans man, one trans woman. Participants did not note this in their demographic forms but discussed it during the interview. Five participants had direct experience with HCPs specific to fertility, four of those participants were currently involved or waiting for fertility treatment, and one was in the process of cryopreserving her sperm. Six participants discussed fertility intentions hypothetically, without having any experience with fertility-specific healthcare, and three worked or were planning to work in healthcare.

Themes

To address the research question, “how do members of the 2SLGBTQ community experience family planning and fertility intentions, and how can nurses support 2SLGBTQ community members throughout these experiences?” I have developed a conceptual framework (Figure 1) based on the data. I explain how participants drew from their lived experiences and believed ideals of normal when imagining their fertility intentions. Ideals of normal included what people believe to be normal (overt or not) based on societal understandings of the norm. Ideals of normal are different for everyone and influenced by intersections of identities. As people move from imagining intentions to actioning intentions, they encounter supportive factors and barriers to achieving their fertility intentions. Supportive and suppressive factors are nuanced, as seeking information, family, and healthcare systems can be both supportive and suppressive. Exclusively supportive factors are connection to a community, and exclusively suppressive factors are societal, biological and financial factors. These factors contribute to the experiences that the 2SLGBTQ community has with fertility intentions and family planning.

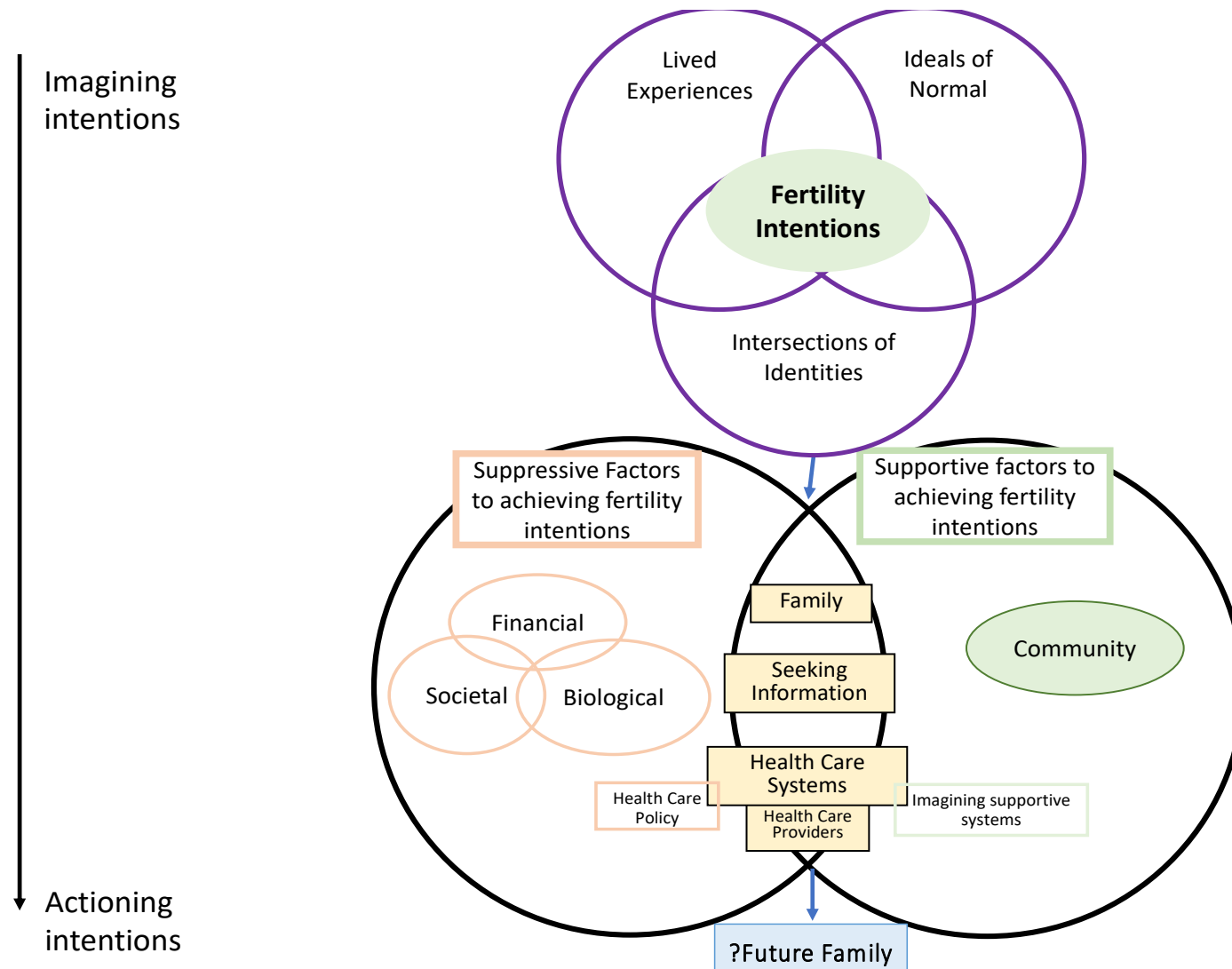


Figure 4.1 Conceptual Framework

Imagining Fertility Intentions

During the imagining intention phase, all participants explained that their lived experiences formed their fertility intentions at the individual level. At the societal level, ideals of normal influenced lived experiences, and vice versa. Intersections of identities - including sexuality, gender, race, and culture - also influenced participants' ideals of normal. Both societal and historical factors influence one's intersections of identities. From these factors, participants conceptualized their fertility intentions in a variety of different ways. Their fertility intentions ranged broadly and included having biological children (either with gametes from them and their partner, or from only one partner), adopting children, using donor gametes (known donor sperm or anonymous donor sperm), carrying the pregnancy themselves, using a surrogate, adopting, or step-parenting. Participants were open to a different number of children - ranging from not wanting to birth their own children, having one set of twins, to three or more. No participant had an exact set number of children they desired.

Participants made intentional decisions when it came to their family plans. Intentional decision making ranged from why they chose specific ways to become parents, how they would want to raise their children, how society and their community would view their decisions, and making life decisions based on the possibility of being single parents.

I guess maybe we will be more intentional in the way that we raise our kid knowing about queer people and thinking about gender and thinking about sexuality and thinking about race and racism and ... I dunno I think we might be more intentional about that then maybe folks that aren't in our position might be. (Sophie)

Sophie explores how they may be more intentional in a variety of ways. For participants, intentional decision making started with the imagining conception phase and extended into actioning intentions with raising a family.

Co-parent relationships affected the ways in which participants explored their fertility intentions. Over half of the participants were in committed relationships and planned to become parents with their current partners. The single participants viewed their co-parenting relationships evolving in several, arguably non-traditional ways, such as single parenting, being a stepparent, or co-parenting with a friend.

[my lesbian friend and I say that if and when] ... we're both 39 and we're both single, and we have nothing going on for us, we should just start making a family. And I'm like – yeah I'm down - And sometimes it is a joke and sometimes it is kinda serious... we're not married, we're not even sexually attracted to each other, we just want to have a baby.
(Tyler)

Being outside of normative identities may offer more opportunities to have a family in various ways. As Tyler shows, because members of the 2SLGBTQ community exist outside of cisnormativity and heteronormativity, more parenting opportunities outside of normative family structures arise.

Intentional decision making also bled into how participants planned to raise their children, with some starting alternative book collections for their future children. Many users from reddit conversed when a pregnant non-binary person asked about gender-neutral names their children call them. Users shared examples from their experiences as non-binary people,

gender non-conforming identities, or polyamorous family configurations such as “Bear,” “Didi,” and “Poppy.”

Because of heteronormativity and cisnormativity, some participants discussed already planning conversations on how to teach their future children about homophobia and the stigmas they may face as children of parents in the 2SLGBTQ community.

I think our future children - hopefully, we will have children - will probably face some - I dunno - bullying or weird conversations like at school, but I think it's becoming more normal these days to see children from queer couples, so I like that. I think that could be a barrier, but we've talked about it in-depth and obviously, we will work through that when that comes. (Hannah)

Here we see that Hannah and her partner have discussed how society may view their future children. Although she could see it as a barrier, she explains that it contributed to the discussion around their fertility intentions. In the end, it did not affect their final decision. This thinking pattern shows both intentional decision-making and emotional labour related to fertility intentions and family planning.

A variety of factors influences fertility intentions. How people view themselves as parents, how they decide to raise their children, and how they anticipate society views them and their family contribute to the multitude of the fertility intentions one has. Because participants exist outside of a perceived idea of normal, there may be more variety in how they achieve their imagined fertility intentions.

Lived Experiences

At the individual level, all participants explored lived experiences as drivers of what they desired for their fertility intentions. These lived experiences included their number of siblings, if they were biologically related to their parents, if they were adopted, and the dynamics of other families they knew. Below, Lea discusses her experiences growing up and how they impacted her fertility intentions: “I grew up with two siblings, so I am the youngest of 3. But I was thinking I would like to have 2 kids like 2 or 3 is what I have in mind, but it’s nothing that is super fixed...” (Lea). Here, Lea shows how she has reflected on her own lived experiences with siblings and how she has based her fertility intentions on what she experienced.

Like Lea, participants expressed being flexible in their fertility intentions. Although participants expressed a preferred way to have their ideal family, all participants explored additional options if things did not go as planned. Additionally, some participants expressed their fertility intentions being outside of their control, connecting it to a higher power or Creator. In contrast, other participants explored their options being affected by specific barriers, which I will discuss later.

Participants’ lived experiences also played a role in whether they desired biological children or wished to adopt. While some participants expressed a desire to be biologically related to their future children, others imagined not having a preference between any way to achieve children – for example, between adoption, surrogacy, or step-parenting.

My whole life, every friend of my parents that I meet they're like “oh you look so much like your dad,” and “oh I can see your mom in you” and I think that it would be kinda nice to be able to raise a kid and have that. (Brett)

The lived experience of physically looking like your parents was what Brett hoped to emulate with his own children one day, showing the imprinting that lived experiences have on fertility intentions. Additionally, and speaking to flexibility, Brett later discussed that he would be open to adoption if needed but preferred the idea of having biologically related children.

One participant was adopted and expressed because of his awareness of the process and his experience he would be open to adopting future children of his own. Additionally, when a user on reddit created a thread regarding how they struggled with the idea of not being biologically related to their children, many other users responded that although they did not carry the pregnancy and were not genetically related, their children had picked up many of their mannerisms. Users agreed that although it was a difficult at first, for them, and at the end of the day it did not matter, and they often forgot they were not biologically related.

Some participants explored how normal can mean different things depending on their experiences growing up. For example, when reflecting on his childhood experiences, Tyler explained that he is interested in being a “community father” similar to how he saw his grandmother. Reflecting on his experiences, he explores that:

...at one point in my life it was me my family, my grandma, my grandparents, my uncles, my aunty, my cousins, like 12 of us living in one house. I slept under the stairs in a sleeping bag. You know? Like I thought it was fun at the time, we’re having a big sleepover, for *laughs* four months! *laughs* But, you know, I am older that I realize that was kind of not normal, that’s not normal to have 12 people living in the same house – or is it?! Or is it, you know? I struggle with that, cause it was normal for me. But then I got older, and I see how other people look at each other and they are so judgemental, and it’s like well, I can’t live like that and I can’t have a child living like that., they’d be like

‘oh my god.’ You know? So yeah, I don’t want that heteronormative idea of family, but I don’t want to be... it’s almost like you have to though, you’re almost forced into it.

(Tyler)

Tyler's lived experiences shaped how he viewed his fertility. Lived experience also showed how normative beliefs challenged what he believed to be normal. These challenges extended into his fertility intentions, where he became unsure of what he could and wanted to do within the confines of a heteronormative society. Although he remembers his childhood positively and as something he would like to emulate, societal pressures may shape his fertility intentions differently.

Ultimately, there are many possible scenarios to envision fertility intentions; one’s own experiences often influence these desires. By creating families outside of heteronormative and cisnormative beliefs, members of the 2SLGBTQ community may have possibilities to explore parenting options that are arguably non-normative. Alternatively, normative beliefs may become internalized and create challenges and barriers for participants to wholly participate in how they want their fertility intentions to be.

Ideals of Normal

Heteronormative and cisnormative privilege extends to every aspect of participants’ lives and exist outside of fertility-specific experiences. When discussing ideals of normal, participants explored them at the individual (if they were normal), societal level (if they were normal within the broader society), which then influenced the 2SLGBTQ’s ideals of normal (questioning who was the most normal within this community). Ideals of normal spanned what society believed to be the most normal in gender, sexuality, personal identities, fertility intentions, family plans, relationship configurations, and race.

Individual Level

Throughout the interviews, participants would casually use the word “normal,” always othering themselves outside of what is considered normal. When I questioned participants on what they believed to be normal, participants responded that normal predominantly involved being heterosexual, cisgender, monosexual, white, and monogamous. Mason exemplified this, as it correlates to an internal battle for participants to recognize themselves as being normal:

So, for the longest time, I was accustomed to think that 'normal' was always part a male and a female, so, it was very hard to - even now I have to sometimes say normal - and that's like, but, no no no no no no. (Mason)

Mason shows how the internal struggle and how he continually has to remind himself that he is still normal although he is not heterosexual. This internalization shows the enormous impact that heteronormativity and cisnormativity have on the perceptions and experiences of the 2SLGBTQ community. The external validity of one's sexual and gender identity is determined by what is considered societally normal.

Furthermore, participants often compared themselves to people they considered normal – for example, monosexual, heterosexual, or cisgender. In the excerpt below, Natasha discusses ideals of normal and how - because she is a lesbian - she exists outside of the normal that is expected of her:

I guess I think that telling people about it, [my sexuality] they're really weirded out because it's not what they expect - it's not like the normal way for people to go, but I'm like I'm not going to be with a guy - I can't go the normal way you guys want me to go. (Natasha)

Participants discussing that being heterosexual and cisgender is the most normal identity shows the privilege that those identities have. Whether recognized or not, many participants have internalized normalized beliefs, ultimately othering themselves into believing they are not what society accepts as normal. These internalized beliefs extend through the lifespan. Participants explore the ideas of normal as it extends to themselves individually, in relationships, and what makes a normal family. Participants developed a sense of the ideals of normal when they were young based on societal expectations and lived experiences.

Societal Level

At a societal level, concerns of being outside of normal existed where some participants discussed knowing that their identities were a threat to their safety. The following passage also highlights additional challenges associated with the intersections of being both gay and in an interracial relationship:

I don't often hold hands out in public because we are afraid we are going to get attacked from some homophobia - we are just going to get insults thrown at us, and we wouldn't have to deal with that if we were a straight couple. Even though it is a [straight] interracial couple it wouldn't make as much of a difference as compared with two guys holding hands or gently kissing each other in public it [being in a gay and interracial relationship] is a bigger deal than it would be if it was a straight couple for sure. (Aaron)

For some participants, being out in public was a threat to their safety, further highlighting how societal beliefs and actions rooted in homophobia and transphobia reinforce the internalized ideals of being outside of normal and thus posed a threat. These beliefs also created barriers for participants to be comfortable, supported and fully themselves when existing in the outside or public world.

Representation

Participants expressed that society perpetuated ideals of normal by mainstream media showing primarily heterosexual, cisgender and White individuals, relationships and families. Many participants discussed that they did not see themselves represented wholly in the media.

Normal can be whatever it needs to be. I think me and my partner are normal, we have a very nice relationship there. So, I am trying to break my mindset of male and female cause that's like what I have seen in so many shows and TV that I watch. (Mason)

As Mason illustrates, not seeing himself fully represented creates an internalized idea that his identity and relationship were not considered societally normal, and he made a conscious effort to reassure himself that he was, in fact, normal.

Some participants explored the effect that gender norms had on how they pictured their fertility intentions and how their gender identity and ideals of normal were affected by their lived experiences of invisibility.

I think I've grappled and I've like seen other queer people or like non-binary people and people like that and I'm like oh - all sorts of people, and I'm like it [carrying a pregnancy] doesn't have to be such a feminine thing. (Leah)

As Leah saw more people like them represented, they saw less focus on pregnancy associated with the female gender only, which expanded their possibilities to carry a pregnancy. These expanded possibilities highlight the importance of diversity in representation as media may be inadvertently perpetuating ideals of normal and risking excluding some identities.

Furthermore, participants expressed feeling as though they were not well represented in media or literature if they had additional intersecting identities. These intersecting identities included not seeking a co-parenting partnership (being single), their race (being an Indigenous person or a person of colour) and plural sexualities (not heterosexual or mono-sexual). For example, at some fertility clinics, participants noted that information on websites and around clinics would feature two white, likely cisgender women. There was an overall lack of diversity in other genders, sexualities, and family configurations.

I guess having people be more accepting like there's more options for getting - more nuclear family that are possible, I think having more representation of that in the media, like instead of representations of this is a married couple this is their child of course they're either going to be usually white and straight of course - or yeah I think seeing more diversity in that would be a good step. I'd probably have a special case because if I'm single, nobody can expect that I'm not not straight - I'd just be a single mother. I think there is a stereotype with single mothers like 'oh they couldn't keep their guy or 'oh she had sex too early, and she wasn't being safe.' (Natasha)

Participants found very limited identities represented in the media. The limits affect how society perceives the 2SLGBTQ community and how the 2SLGBTQ community views itself. Lack of inclusive representation creates a normal vision where some are othered because of their identities. Although participants felt normal in their own way, they experienced an internal struggle to acknowledge and justify that they were normal.

Within their own identities, participants discussed that media influenced how they viewed and understood themselves. For example, some participants held internalized beliefs from the

negative representation of their sexualities being called “crazy,” “transient,” “deviant,” “hyper-aggressive,” and “predatory.” Ultimately, these negative representations influenced how they experienced their identities.

I lamented over the fact that like why couldn't I have been born a lesbian - I would have been so much happier girls are so much more better... but since I didn't have that hypersexual predatory thing – “yep can't be a lesbian I am a normal person...” is what I was thinking. (Natasha)

When media represents limited identities, it creates invisibilities and narrow ideas of the identities that people can be. These identities that are made invisible are then typecast or seen as tropes, affecting how individuals come into their identities. A lack of representation or misrepresentation in the media - and thus society - can affect how individuals see themselves, understand how to be, and ultimately the way they live their lives.

On the upside, participants expressed a recent shift in media to see a more accurate representation of the 2SLGBTQ community. “...generations a little younger than me have a bit more representation for in their communities in like, cartoons? I think Steven Universe is one of them, in which mainstream media has some representation of those [2SLGBTQ] labels” (Ray). Considering that representation was shifting with new media, TV shows and cartoons such as 'Schitt's Creek' and 'Steven Universe' were highlighted as representing characters outside of the norm. This shift created feelings of hope for future generations of 2SLGBTQ youth and the belief that there is increased societal tolerance due to representation and the understanding of a variety sexualities and genders.

Community Level

Ideals of normal, representation, and invisibility contributed to what some participants discussed as a hierarchy of identities within the 2SLGBTQ community. Societal expectations and understanding of who and what are the *most* normal create this hierarchy.

My understanding of nuclear values are kind of the structure or the idea that the ideal family is like a man and a wife. Or nowadays I think it's also kind of mutating into people of the same sex being married under law, and having around two biological children of their own, settled into like your own home in the suburbs, kinda thing. (Ray)

With this, participants explored that even within spaces that accept the 2SLGBTQ community, there may be a hierarchy among identities or identities seen as 'more normal' than others. This hierarchy understands that some identities within the 2SLGBTQ community (for example, monosexual and cisgender) were more palatable and accepted among society.

Participants explored this idealized hierarchy as it related to policymaking. Some policies may accept cisgender and mono sexualities (same-sex – gay and lesbian) identities but may not accept trans genders, and plural sexualities (pansexual or bisexual). Participants also discussed this shift with support groups for the 2SLGBTQ community. Many organizations offered supports for monosexual, married and white families, but less so for others.

Additionally, there was also discussion that some members of the 2SLGBTQ community were continually striving to fit within society's definition of normal. Participants explored that being a same-sex couple was accepted, celebrated and normalized if they lived the 'normal' life – white, married, monogamous. In contrast, those outside of what was seen as normal may not experience the same benefits within society.

Ideals of normal are broad reaching, internalized and manifested beliefs based on lived experiences and intersections of identities. They are displayed at the individual, societal, and community level and affect how individuals perceive themselves and others as it relates to an idealized normal. Ideals of normal affect not only how one views their future family, but also into individual identities with how they present themselves in the world.

Intersections of Identities

Participants explored parts of their identities that influenced their ideals of normal. These intersecting identities affected what they believed to be normal and how they experienced normal within the greater society. Most often, intersecting identities involved sexuality, gender, race, and culture. Intersecting identities also affected their lived experiences.

Intersecting identities overlapped with ideals of normal and lived experience. For example, when Tyler discusses his fertility intentions related to his experience as a Two Spirit gay man, he explains how his experience differs from that of others in the 2SLGBTQ community:

...this is something that I have seen too, not in Two Spirit people but in gay people, they, they're – especially white, gay males – they want to get married, and they want to like adopt a baby and everything, they wanna have – it's kind of like the gay ideal family structure (Tyler).

This passage further highlights that the 2SLGBTQ community is not a monolith, and there are many different identities and ideals that contribute to what one may consider normal.

Furthermore, some people may strive to be seen as normal within heteronormative and cisnormative societies, while others may have a different understanding of what is normal.

Participants explored intersections of race and sexuality related to representation, where individuals' whole identities were not represented. For some participants, intersections of identities played into their fertility intentions. They already considered themselves outside of normal and felt that having children may continually draw unwanted attention for being different.

... it [my relationship] feels very different compared to everything I have seen in interracial racial relationship between a male and a woman. But because we are both males and like also very different in a racial status it is very - I feel like that gets a lot of attention when we go out in public there... and I feel like along with having kids who might also be different from us because we cannot combine our DNA together *laughs* it will be very, I guess - per say - out of the normal. Speaking to normal again (Mason)

This passage highlights the intersections of identities, societal xenophobia, and the internalized struggle of perceiving oneself as normal in a society where your identity may not be represented or considered as such. I will explore intersections of identities throughout the following sections as they are entangled within all participants' experiences.

Supportive and Suppressive Factors to Achieving Fertility Intentions

As participants moved into actioning intentions, they explored the supportive and suppressive factors associated with their fertility intentions and family plans (Figure 2). Again, these factors were nuanced and entangled. Some factors acted both as supportive and suppressive depending on the intersections of identities and lived experiences. When actualizing intentions, there were also supportive and suppressive factors. Exclusive barriers were financial, biological

and societal. The sole supportive factor was the community, and overlapping supports and barriers included family, seeking information and healthcare systems.

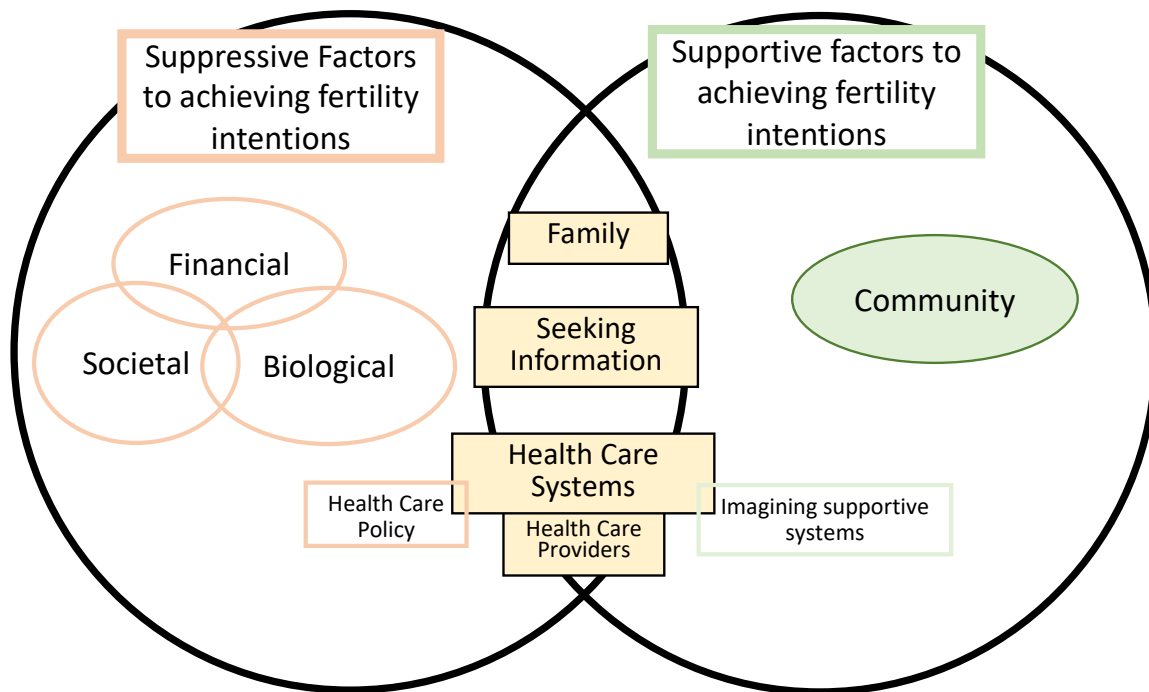


Figure 4.1 Suppressive and Supportive Factors

Suppressive Factors

Financial Barriers

All participants expressed finances as a barrier to achieving their fertility intentions. Financial barriers existed from a personal view of having current low income and the cost of fertility treatment and extended into the broader costs of raising children and the current financial pressures that their generation is facing. Aaron discusses his intentional decisions around when he is financially ready to have children - “financial stability - it's huge. I’m not going to say I am

ready to have children until I have that financial stability and that is from dual income” (Aaron). Again, Aaron shows the intentionality behind the decisions he is making.

Like Aaron, participants discussed how they were mitigating the financial barriers which included choosing specific careers to support their family and getting a job in a location that paid a higher salary – even if it involved being away from your family or support system. Lea discusses how some barriers intersect, discussing multiple financial barriers that members of the 2SLGBTQ community may face:

I do talk about finances a lot but I do think about that a lot, and for a lot of people that is one of the biggest barriers really, even if they can get in with really good medical providers and everything ... that [financial] is one of the biggest hurdles. (Lea)

Financial barriers discussed by participants overlapped both with societal barriers and biological barriers. Depending on the availability of gametes in a relationship and fertility intentions, some couples may need eggs and a surrogate, where other couples may only need sperm. Both the cost and accessibility to gametes and resources then affect how members of the 2SLGBTQ community can achieve their fertility intentions.

Biological Barriers

Biology created a barrier for many participants, as they literally could not conceive children in their current partnerships. Biological barriers were known to most participants before planning their fertility and contributed to the intentional decision making and emotional labour that went into their fertility decisions. “It’s been a conversation from the start because, obviously, we knew we wanted to have kids but neither of us had sperm” (Emmett). From users on reddit, biological barriers also intersected with their gender by being unsure about getting

pregnant while on testosterone therapy and lack of clarity in legislation, where they were unsure how they would be represented on birth certificates.

For some participants, age created barriers. Some participants felt as though at present they were too young or not in the right stage to have children. Alternatively, HCPs told some participants that their age was advancing and created barriers for them to proceed with the treatment they desired. “I might have some complications - but I don't know yet - so we need to get my eggs out of me first and I would like to carry first also because of my age” (Hannah). Hannah explained that her age took away the possibility for her and her partner to do reciprocal IVF – where one partner carries the other partner’s embryo that has been fertilized with donor sperm. Later, the second partner will carry an embryo made up of the egg from the first partner and the same sperm donor. Unfortunately for Hannah, this barrier overlapped with financial as, because of provincial funding and her age, they were unable to do treatment in the way that they desired.

For participants, finances and life-stage correlated with the ability to support a family. These correlations occurred on multiple levels, including their maturity level and capacity for raising a family, which then correlated with age, where they were either too young or unfortunately, not young enough to achieve having children in the way they imagined.

Societal Barriers

Societal barriers existed for participants as they spoke about the power that some institutions, policies and cultural beliefs had to create challenges and oppressions for the 2SLGBTQ community. These barriers included the state of the world and negative societal beliefs around the 2SLGBTQ community.

State of the World. Many participants discussed the current “state of the world” as a potential barrier to them having children. Concerns included the climate crisis; violence, politics and feeling of an impending civil war - specifically in the USA; school shootings and kidnappings; poverty and health inequalities; and gender norms and homophobia

Tyler explores the differences generationally how the world is now, compared to how it was when his mom was parenting him:

...especially now, with the cultural climate – my mom is always talking about the news, and everything she sees in the news, the world is so scary, I wouldn’t have a kid in this day and age with all the kidnappings and kids going missing and drugs and everything.

So, it isn’t just finances but the culture we live in (Tyler).

Overlapping barriers created additional intentional decision making among the 2SLGBTQ community, as Tyler explores above. Tyler’s statement also overlaps with lived experience, as the discussions with his mom have shifted his perceptions of the world in which he will raise children. Although participants discussed the state of the world as being a barrier, all participants but one still planned on having the family they intended. One participant discussed that if the world did not change, they would chose not to become a parent as it was not fair for their future hypothetical children.

Similarly, a conversation from reddit prompted a discussion around the intentional decision making around having children for members of the 2SLGBTQ community compared with “cishets” - those who are cisgender and heterosexual. Users discussed that they desired children, but because they were intentionally choosing and needing to take steps outside of intercourse to have children, they were worried about being selfish when the state of the world was so uncertain. The thread prompted multiple conversations around the intentionality between

cishet people and the 2SLGBTQ community family planning and the societal expectations that arise as such.

The thread also created a space for users to discuss their experiences when telling people about their family plans. Users reported receiving an intense amount of scrutiny from friends, family and colleagues because of their decisions. The thread concluded with users agreeing that members of the 2SLGBTQ community are intentional in their decision making and are just as capable of being parents as cishet people and should not be held to higher moral ground because of this.

Societal Beliefs. Participants discussed homophobia and transphobia within society and how these phobias may potentially impact their future children. Participants explored these concepts intentionally, which involved how they would educate their children, how they would raise their children, and how they would approach bullying.

I don't want our children to have to be exposed to homophobia. Yeah, we are going to have conversations about it with them about it from an early age, absolutely but I don't want them to live in a world where that is a socially acceptable thing. We are in the world of changing it, but it's a long process... (Aaron).

Aaron shows hope that, although slowly, the world is making progress in overcoming phobias. We can see that these societal beliefs also extended from the ideals of normal and intersections of identity, where existing outside of what would be considered a normative relationship (for example, being single and parenting) or normative ideas of parenthood may contribute to additional barriers and harassment for some.

Overall, societal barriers existed for the 2SLGBTQ regarding their fertility intentions and family plans. Although it may not change their desire or actual plans, these barriers add

additional challenges for members of the 2SLGBTQ community to achieve their desires, including emotional labour and intentionality in the decisions made. Societal barriers also coincided with notions of hope, where participants were hopeful that the state of the world would be more positive in the future.

Supportive Factors

Sense of Community

Community was a supportive factor across all participants. The exclusively supportive community that participants described most frequently included other members of the 2SLGBTQ community with similar experiences. The overlap in experiences included both those individuals imagining fertility intentions and actioning fertility intentions.

For those who were imagining fertility intentions, supportive communities were most often those with similar intersecting identities, for example, similar sexual orientations – or an understanding of same - and similar cultural backgrounds or understanding. One participant explored their identity as being pansexual and the importance of finding a community that understood what that meant for her. Other participants explored how their main community were people that were similar to them and understood the experiences they have faced.

...most of my friends are Indigenous. Most of my friends - I don't have a lot of white friends. And if I do, they are really good allies, but mostly, Metis, especially in academics, I have a lot of friends that go to university too. And so, I think a lot of us, but I think some of us are radicalized and people who are like really passionate and fed up about a lot of things. So we are, really cognizant of the colonial perspectives of things, and so we are thinking of historical context all the time. (Tyler)

Tyler's passage highlights the importance of finding communities that understand and support your identities, share in similar conversation, and support each other in the additional barriers that you may be facing based on identities.

For participants moving towards actioning fertility intentions, supportive communities with experience of fertility action proved to be the most important. These supports included friends who had previous personal or work experience with fertility treatments, or strangers going through treatment processes. Some participants explained they had arranged Zoom meetings with friends of friends who had gone through the fertility process because they had felt so lost, or reached out to strangers through the internet. "Finding these Facebook groups where I'm just like - I'm just gonna message this random person, and I don't care because I am so alone in this" (Hannah). From these support groups, participants were able to find others who were going through similar things they were, and they were able to confide in them for help, support and knowledge.

Like Hannah, participants discussed that as there was no community currently in existence, they created their own. Needing to create your own community also relates to increased emotional labour experienced by some participants. Users on reddit often shared how much they appreciated the subreddits related to queer parenting, stating how helpful the resources, other users, support, and information was. This appreciation shows that there is a personal level associated with community support, where – even in an online domain – reading and learning about other people's stories and experiences is exponentially valuable.

Overlapping Supportive and Suppressive Factors

Participants explored the dichotomy between some factors, where participants saw some as being positive and supportive, and other times as being negative barriers. As participants

engaged in imagining and actioning intentions, they experienced nuanced factors, which included family, seeking information and healthcare systems.

Supportive Families Versus Families That Suppressed

For some participants, family offered a system that supported them throughout their process – both in imagining and in actioning. Alternatively, other participants experienced challenges within their family system – either immediate or extended – that created barriers during the family planning period.

Supportive Families. In the imagining phase, some participants explored that it “takes a village” to raise a child and that they expected their family would help them out in any way needed.

That saying it takes a village, well my village is huge, and I am very, very lucky and thankful for my village. I think that if I needed - if it turns out that I am going to be a single parent - then I think that is a huge thing that if I would be able to lean on my family for sure, my friends are amazing. (Brett)

As Brett explores his relationship with his family, we also see the intentional decision making that has gone into his fertility intentions. If he is a single parent, he knows that he can rely on his family and community’s support. These supports also extended into the actioning phase when participants relied on their family as a support system to navigate the challenges experienced during fertility treatment.

Some participants explored the challenges when undergoing fertility treatments and how this created additional decisions related to telling their family. For example, because of the increased need for support due to the additional challenges (emotionally and financially) related to undergoing fertility treatments, participants expressed they would want to tell their family so

they would have family support. However, if they relied on their family for support, the choice to surprise their family with news of a pregnancy was removed.

Because it is such a difficult process, so like if one of us gets pregnant I guess with our family, they're just going to kind of like know - so I guess the surprise, the opportunity to like the announcement or whatever is removed. (Leah)

Leah's experience shows the intentionality and emotional labour within the decisions that are made in the imagining and actioning phase of family planning. Their experience also shows the overlapping factors within support – where family can act as both a support and a barrier because of emotional support needed from facing the emotional task of fertility treatments within heteronormative and cisnormative systems.

Suppressive Families. Some participants expressed that their families were not a source of support. Participants explored this barrier by discussing how their parents would likely not see their children as being grandchildren as they weren't biologically related to them, "I am pretty certain I think my parents aren't going to see the kids as a 'grandkid' like a 'grandchild' things like that. But nothing that would prevent us from doing it" (Emmett). Again, Emmett shows that although he has faced barriers, he has acknowledged that he will proceed with having children as planned, highlighting both the intentional decisions and the emotional labour.

In looking at the intersections of identities, Mason explained that his extended family did not know he was gay, and he was not sure at what point he would tell them... "how do I say like 'oh I have children, but with a boy, with another male'" (Mason). For Mason, although his immediate family was supportive, his extended family created additional challenges as his culture may not accept homosexuality and he may be shunned because of his identity.

From both examples, we see that participants acknowledged the barriers and challenges within their family. Still, it did not prevent them from achieving their desired fertility, showing the intentional decision making, and additional emotional labour that members of the 2SLGBTQ community may experience specific to fertility intentions and more broadly.

For some participants, family can be an incredibly supportive and motivating factor, both related to fertility intentions and more broadly related to supporting their children's identities within the 2SLGBTQ community. Families can also create challenges, specifically related to fertility intentions and family planning, and more wholly accept identities within the 2SLGBTQ community. Participants explored both dichotomies, which were often overlapping.

Finding Information Versus Dearth of Information

When asked how they would find information related to family planning and fertility intentions within the 2SLGBTQ community, all participants reported they would go online. Participants discussed that, although there was a lot of information available, finding information specific to their needs and location was difficult. Participants also explored that it was challenging to know if you could trust the information based on the source and differences in services, locations, and needs. When asked what advice she would give to others trying to find information, Lea replied:

...it's hard to find anything that kind of isn't the norm. but you know, maybe that's why for someone - but someone else needs to be a different path. and yeah, really just kind of take it slow and make sure you get the information that you need. (Lea)

This passage highlights the ideals of norm and how heteronormativity and cisnormativity can make it challenging for members of the 2SLGBTQ community to find information. As well,

considering there are a vast number of different identities within the community, what is right for one person may not be relevant for another.

There was also a lack of clarity on accessing policies for members of the 2SLGBTQ community. For example, participants that were undergoing fertility treatments faced challenges finding specific protocols and policies and felt as though there was a lack of transparency within the clinics. This lack of transparency left participants feeling excluded, confused, and discriminated against. “I think the world is not set up for same-sex couples, I feel like there are barriers in conversation, there’s barriers in policy, there’s barriers, in like everything, really” (Hannah). Hannah discusses the barriers related to her experiences when accessing fertility treatments and how there is a lack in accessing helpful information through many different sources.

The lack of clarity on policies extended into lack of knowledge on adoption policy as well. Many participants discussed adoption, expressing a lack of clarity on the need for individuals to be married, income requirements, and general rules and regulations for members of the 2SLGBTQ community. This lack of relevant and correct information related to adoption can create additional barriers, where members of the 2SLGBTQ community may not know if they are eligible to adopt, ultimately affecting their fertility intentions.

Like finding supportive groups, individuals found the lived experiences of other members of the 2SLGBTQ community going through similar processes to be invaluable. Some participants explained that because of the information they found from others online, they would be much more likely to share their story online as well, in hopes to support others, answer questions, and alleviate any undue stress. Here Sophie explains:

...there are a couple of like Facebook groups as well, about like queer folks trying to conceive. And with some of the fertility clinics in [location] have Facebook groups which can be a bit of a nightmare but also helpful. You kind of have to weed through. (Sophie)

Here we see that the information available to members of the 2SLGBTQ community is accessible and available but can be challenging to find information relevant to you. The lived experience of other members of the 2SLGBTQ is a promising resource for those navigating a system wrought with barriers.

For members of the 2SLGBTQ community imagining and actioning fertility intentions, there may be information available. Still, it also may be challenging to find information that is specific to their individual needs, desires, and scenarios. Because finding relevant and appropriate information easily is imperative for understanding the process and systems, when individuals can understand and access and navigate systems, they are more likely to have positive responses.

Supportive Healthcare Systems Versus Barriers in Healthcare Systems

Supportive healthcare and healthcare barriers existed for all participants, regardless of whether they were in the imaging or actioning phases. Supports and barriers also extended outside of fertility intentions and into everyday lived experiences. I have broken down healthcare systems into two parts: healthcare policy and HCPs. These two systems overlap, as HCPs are carrying out healthcare policies. It is an important distinction to make as HCPs could be advocating for more inclusive policies. From the participants' discussion, there were no supportive healthcare policies they experienced, but participants discussed imagined experiences that would make healthcare systems more supportive.

Healthcare Systems: The Visible Rainbow Dilemma. Participants discussed the nuances with inclusivity and safety in spaces, ranging from restaurants, hair salons, schools and healthcare settings. There was some debate regarding visibility via the use of rainbows and pride flags in offices or an increase in 2SLGBTQ representation in handouts or visual posters. Some participants found symbols helped know that these places were inclusive; others felt that the representation was superficial as they still had negative experiences despite the presence of 2SLGBTQ symbols. Natasha discussed the nuances with some of the symbols, “alluding to those, sort of those challenges with those flags in the sense of sometimes they mean, sometimes they can be very superficial, but they can also be the symbol of safety” (Natasha). With this, participants acknowledge the complexities and knowingly contradicted themselves in saying that even though they knew flags and rainbows could be superficial, it was still nice to see them.

Healthcare Policy.

Barriers in Healthcare Policy. For some participants, barriers within healthcare made them feel discouraged and marginalized, for example, the long wait times and intense planning related to any sort of decision around fertility – “Timing is really a choice that is taken away from us. So basically, we can start trying when we get to the top of the IVF waitlist” (Hannah). Some participants knew that the fertility journey took a long time and started almost two years before they wanted to conceive a child. Lack of autonomy and representation for participants often left them feeling hopeless and invisible. Of the participants who had experience within fertility-specific healthcare settings, four out of five felt that clinic policy did not represent any aspect of their identities.

Three participants worked or studied in healthcare and offered unique perspectives based on their experiences as HCPs. These participants spoke about advocating or being more aware of

patients' needs that could be 2SLGBTQ. Participants also found a lack of 2SLGBTQ specific content provided in their education and found themselves often advocating for the 2SLGBTQ community within their working or school environment. When asked if they had found that 2SLGBTQ topics were taught in nursing school, one participant laughed and replied "no, no, not at all."

I think that we've got a long way to go in terms of being more diverse in terms of that education. I don't remember being touched on non-binary or transgender or any of those types of different identities or any other type of orientation because I've talked to my nursing friends about certain things because being a part of that community I like to educate myself about that so I am usually the person to come to if you have any questions about that, and I am able to try and answer or I'm not perfect myself and I will direct them to a resource. (Brett)

These examples show that even those with insider knowledge of the healthcare system feel a lack of support, education, knowledge, and advocacy for members of the 2SLGBTQ community. This example also highlights the increase in emotional labour experienced by members of the 2SLGBTQ community generally and specifically when working within healthcare as they are continuously advocating to validate their identities.

Some participants discussed being role-models or mentors for members of the 2SLGBTQ community and heterosexual or cisgender people. Participants took on this emotionally laborious role as they knew resources geared towards 2SLGBTQ identities were lacking for both communities due to the lack of inclusive education and policy. For example, Ray discussed how she took on a mentorship role for other members of the 2SLGBTQ community because she knew

there was little specific information around safe sex practices. At the same time, Brett took on an informal role where he was open to answering questions that his cisgender and heterosexual colleagues and friends had specific to the 2SLGBTQ community.

This emotional labour coincided with individuals' identity as well – where those with additional intersecting identities often had more ways in which they were advocating for themselves or teaching others. Tyler explores that advocating for oneself comes with challenges and is not always an easy thing to do, especially for those experiencing oppressions.

But I think that's a hard thing for some people to do, to sit down and advocate for themselves, and let their intentions be fully known. It takes a lot of bravery to do that, and some people just.... Especially if you are fearful of that, fearful of doctors and that whole thing. (Tyler)

Tyler further discussed the power imbalance between HCPs and patients and the role that HCPs have in ensuring they are providing space for people to be comfortable advocating for themselves, disclosing their full identities to be treated holistically, appropriately and comprehensively.

Participants with experience in healthcare systems specific to fertility intentions and family planning discussed barriers within the healthcare system. These barriers included a lack of policy that was 2SLGBTQ friendly and inclusive, representation on forms, decision-making autonomy. Participants expressed feeling that in highly gendered areas, policies and practices were heterosexist, transphobic, and ableist.

I guess that was an example of something that felt very not inclusive. like they even though we knew that we weren't going to use [my partners] eggs and that he didn't have

sperm to use they still made us fill out the 'female' form for him that went through like menstrual history and pregnancy history and all of that. (Sophie)

This passage highlights transphobia and heteronormative and cisnormative privileging within healthcare policy. The passage also highlights the ability of healthcare policy in devaluing the lived experience and intersections of identities for participants. Participants also explored how systems create normative boxes for people to fit within. With these normative boxes, there are increased barriers for those who fit outside of same.

Healthcare policy is based on heteronormative and cisnormative beliefs that affect how members of the 2SLGBTQ community access healthcare. These policies create barriers and perpetuate violence in their everyday interactions with healthcare systems and into fertility-specific and highly gendered areas.

Healthcare Providers.

Barriers with Healthcare Providers. For those participants who did not have fertility-specific healthcare experiences, accessing supportive healthcare services proved challenging. Concerns included how HCPs would treat participants if they knew they were in the 2SLGBTQ community. Participants also feared being outed to HCPs accidentally. If they were outed, they then feared the care they received would be affected. This fear also extended into the treatment of family, friends, and partners.

...[there is] still quite the amount of stigma around your gender expression, gender orientation and how that affects the speed in which you're helped and how seriously your reported symptoms are considered and just how much you're respected in general so.. those stories I guess are kind of the reason I don't really put myself in that situation, or I

conceal my sexual orientation so that, you know, it doesn't go awry if that makes sense.

(Ray)

Ray discusses feeling the need to conceal her identity and dressing in a way that would make her appear straight when accessing healthcare. Ray's actions relate to intentional decision making outside of fertility intentions, as members of the 2SLGBTQ community may need to decide how they want to be perceived and presented quickly. These actions also highlight the effect that heteronormativity and cisnormativity have throughout healthcare, not just related to gender-specific areas.

Related to the intersections of race, participants discussed how their race and culture might impact the care they receive from HCPs. One participant discussed specifically how, because of her lighter skin, she is treated better by HCPs and therefore has less fear that something unwanted – like forced sterilization – may happen compared to her darker-skinned relatives. For some, their overlapping identities, including race, culture, gender, and sexuality, intersected, as seen when Tyler discusses his distrust in HCPs. “I am distrustful of doctors too, like I am worried that if someone were to give me the wrong opinion or if someone were to have their bias around Two Spirit people, aboriginal women, gay people, you know?” (Tyler). In this expert, we see first-hand the multiple identities that can create additional barriers when working with HCPs within the healthcare system.

As HCPs act within the healthcare system, lack of inclusive policy may cause HCPs to act and react in a less than supportive way towards communities outside of prescribed normative boxes. HCPs constitute a significant part of the healthcare system and in the patient's journey. Barriers on account of HCPs are likely deep-seated within cultural understanding, historical

events and internalized racism, homophobia, and transphobia that is perpetuated within the system.

Supportive factors with HCPs. Only participants that had experiences with fertility specific healthcare services discussed the supportive factors they experienced with HCPs. Most other participants did not have consistent HCPs or reported that their HCPs did not know or ask about their sexual orientation. Below Lea shares her positive experience and lists the key factors of the clinics being holistic, access to services (referrals), supportive, inviting, and friendly.

My family doctor - she's amazing - and she really does take like a holistic approach, looking that the whole person and looking at the physical side and also the mental and you know like what really contributes to everything. She has been amazing for getting me referrals to really good doctors that have more access to that kind of care, and my endocrinologist that I talked to is also really, really good. and the reproductive clinic where I mean most of it will happen, they've been, they've been super inviting and friendly and super supportive and any questions I had they would answer right away.
(Lea)

Similar to what Lea explained, participants discussed how HCPs acted as gatekeepers to their treatment options, and when gates were open, and HCPs were supportive, the entire process went more smoothly.

Imagining Supportive Healthcare Systems

When asked about what made spaces feel safe and inclusive, participants explored various things contributing to this feeling. Some participants offered concrete suggestions - such as HCPs having 2SLGBTQ stickers, having Indigenous art on the wall, or making spaces feel

less sterile. Other suggestions were more abstract, less specific, and based on an innate feeling where you “just know.”

Furthermore, what was safe and inclusive for some was not safe and inclusive for others and varied depending on intersecting identities and lived experiences. Ultimately, participants discussed positive spaces where staff were friendly, open, accepting, kind, and were supportive of their journeys. Participants discussed the importance of the staff that worked in different services and the importance of employers providing support to their staff to promote equality. Like ideals of normal, participants expressed simply wanting a space to feel normal... “it is nice to have it just feel normal. People are just educated in basic human rights I guess” (Emmett). Specific to healthcare spaces related to fertility, participants would feel safer and more included when there was transparency in policies and autonomy over their decision. Participants also felt safe and included when treated with respect and when HCPs understood their differences.

In summary, members of the 2SLGBTQ community are asking for HCPs to treat them with respect and kindness so they can exist in their authentic selves without fear or shame.

Indigenous Participants

As noted, Indigenous Peoples are often made to be invisible. Additionally, the intersecting identities for members of the Indigenous community that are also members of the 2SLGBTQ community create additional invisibilities. Thus, I chose to highlight specific results that Indigenous participants shared within this study. In this study, two participants identified as Indigenous - one as First Nations, and one as Dene/Metis. The participants' experiences highlighted the history of colonization and trauma within healthcare systems, the lack of trust of White providers, and the additional challenges they face.

One participant explored the invisibility they face at the intersections of their identity, highlighting that there are “very rarely LGBT perspectives, or even Indigenous perspectives included in the conversation, especially in healthcare.” Additionally, both participants discussed how their Indigenous family and friends often experience challenges when accessing healthcare, but they may not face the same challenges because of their lighter skin. One participant also expressed the fear they have that family and friends may experience, like forced sterilization, based on the history within the healthcare system. The findings further highlight racism and colorism within healthcare systems, the challenges Indigenous Peoples face when accessing healthcare, the resilience Indigenous Peoples have in navigating systems of oppression, and the importance of decolonizing healthcare systems.

Arts-Based Research: Making Meaning Through Collage

Through collage creation and engaging in ABR, I further explored and solidified these themes. As the original intent for ABR was to engage with the 2SLGBTQ community to help form the interview questions, I was disappointed that I was completing the collage independently, had low expectations, and was unsure what the outcome would be. To start, I began cutting out pieces that I thought were interesting, and soon after connecting, the themes started to unfold. When completing the collage, the themes that emerged related to the idea of the future, hopeful alternate realities, and the experienced normative ideologies.

A common sentiment expressed among participants was hope for the future. Through collaging, I explored how this would mean that our society must change the narrative to be more supportive and inclusive of members of the 2SLGBTQ community. The collage brought up a sense of flowing from one experience to the next, being in a state of transition. It also showed how each phase is dependent on the other, and without taking action, there will be no change.

Collaging highlighted the importance of planting the hopeful seeds of change to harvest the dream of a future. In this brighter, balanced and more equitable future, heteronormative and cisnormative ideologies are a thing of the past. However, change does not come without work, allies and advocates. For seeds to grow, they need care and attention. In this case, that involves taking action as change-makers. Engaging in collage led to further reinforcing the importance of nurses taking action to create this future



Figure 4.2 Collage of Fertility Intentions

Summary

Participants drew from their lived experiences with ideals of normal when imagining their fertility intentions. Intersections of identity, including race, gender, sexuality and culture, impact the lived experiences and ideals of normal for participants. The movement from imagining intentions to actioning intentions includes supportive and suppressive factors to reaching fertility goals. Availability of information, family influence, and experience with healthcare systems impact how the 2SLGBTQ community experiences fertility intentions. These factors could be either supportive, suppressive or both, depending on circumstances. Representation played a significant role in participants understanding their identities and what opportunities were available to them. Participants experienced intentional decision-making both with imagining intentions and when actioning intentions. Participants expressed emotional labour in day-to-day interactions and when specific to fertility intentions and family planning experiences. The findings highlight the influence that heteronormativity and cisnormativity have in dictating what is societally normal, the power that the healthcare systems and providers have in policing choice and experience, and how that trickles down to affect the lived experiences at an individual level. In the next section, I will discuss the impacts these findings have, the implications for nursing practice, and why this research matters.

Chapter V – Discussion

In this study, I sought to learn more about the experiences of the 2SLGBTQ community related to fertility intentions and family planning. What I found was when imagining one's fertility intentions, three overlapping factors — intersections of identity, lived experience, and socialized and personal ideals of normal — shaped one's decisions and desires. On the way to actioning intentions, the 2SLGBTQ community encountered supportive and suppressive factors that shaped their family planning experiences. As well, the fertility-related decisions made by the 2SLGBTQ community are intentional and require emotional labour. Regardless of any barriers or suppressive factors faced, community members continue to imagine or action their future fertility. Challenges faced were largely due to heteronormativity and cisnormativity — ideologies that play a prominent, overarching role in shaping perceptions of what is normal. These ideologies shape the experiences of the 2SLGBTQ community by influencing societal perceptions of normal. Although heteronormativity and cisnormativity (and arguably many normative ideologies related to body, race, and relationship status) are far-reaching and have significant impacts on all areas of health (and arguably daily life), in this chapter, I will (mainly) focus on the effects that heteronormativity and cisnormativity have in dictating the experiences of the 2SLGBTQ community specific to fertility intentions and family planning.

Heteronormativity and Cisnormativity

Normal Identities

The findings from this study demonstrate that wholly acknowledging the role heteronormativity and cisnormativity play within the fertility intentions of the 2SLGBTQ community is imperative. Prominent heteronormative and cisnormative ideologies create what society believes to be the most normal identities. The literature agrees that the most desired,

normal, and thus privileged identity is wealthy (Dahl, 2018; Weissman, 2017), White, heterosexual and cisgender, monogamous, and reproducing (Lane, 2019). As hierarchies exist among all identities, the concept of normal ripples to the identities within the 2SLGBTQ community, making some more valued than others. For example, Dahl (2018) extrapolated that — when related to reproduction — educated, middle-class women in same-sex relationships were centred and privileged over other 2SLGBTQ identities. This was shown through visibility and centering of some narratives over others, highlighting White, wealthy, and athletic cisgender lesbian parents as the new “modern family” (Dahl, 2018).

Furthermore, Carroll (2018) explored how gay fathers — specifically single gay fathers, gay fathers of colour and gay fathers who had children in heterosexual contexts — experience stigma and are devalued. Again, this is shown through representation and visibility that makes White gay fathers in couples more palatable than other types of fathers (Carroll, 2018). Tasker and Gato (2020) explore this hierarchy of normal where — specific to adoption — some identities (same-sex and cisgender) are privileged over others (trans or gender non-conforming). Again, this privileging highlights the broad-reaching implications that normative ideologies have in dictating what is most normal and subsequently oppressing those who are not.

Socialization of what society dictates as normal influences one’s identity development (Eliason & Schope, 2007). Someone fitting outside of normal can internalize feelings of oppression and marginalization that may lead to shame, anxiety, and victimization (Eliason & Schope, 2007). Participants show this internalization through self-talk, reassuring themselves they were normal, but inadvertently or subconsciously discussing themselves as outside of normal. Being outside of what is normal can also lead to Othering, where groups are excluded and barriered based on their identities (Debnath, 2017). Othering highlights the complex nature

of power and privilege within the 2SLGBTQ community, where some identities experience additional barriers and oppressions compared to other communities (Debnath, 2017).

These normative ideologies create challenges for the 2SLGBTQ community, specifically within highly gendered areas of healthcare, areas of healthcare that are not gender specific, and areas of society unrelated to healthcare. This reach shows the influence and impact that heteronormativity and cisnormativity have on the overall lived experiences of the 2SLGBTQ community.

Impacts of Normative Ideologies

Although the 2SLGBTQ community is not a monolith, similar findings from research with diverse identities further show the impact of heteronormativity and cisnormativity. For example, similar experiences of intersections of identities, lived experiences and ideals of normal were shared between queer women of colour in the United States (Karpman et al., 2018), lesbian mothers in Poland (Mizielińska & Stasińska, 2019), and sexual and gender minorities in India (Bowling et al., 2019). One may expect different findings considering my research included multiple identities within the 2SLGBTQ community in two Canadian provinces; however, overall conclusions remain similar, further pointing to the role that heteronormativity and cisnormativity have in defining and dictating what is normal.

Institutional Oppression

Healthcare

Heteronormative and cisnormative ideologies and practices are rampant within healthcare settings. This dominance is partly shown through a lack of 2SLGBTQ specific reproductive education for HCPs, and reproductive treatment protocols that privilege those who are heterosexual and cisgender (Tasker & Gato, 2020). Healthcare systems and providers may also

perpetuate heteronormative and cisnormative ideologies. The experiences of trans individuals exploring surgery, hormones, and treatment options illustrate this perpetuation (Occhino & Skewes, 2020). In these cases, HCPs act as gatekeepers to treatment and perpetuate normative ideologies, transphobia, homophobia, and biphobia through dictating the most normal way to be trans (Occhino & Skewes, 2020).

Similarly, within healthcare settings, members of the 2SLGBTQ community face nuanced experiences through HCPs being supportive, suppressive, or both (Appelgren Engström et al., 2018; Tasker & Gato, 2020). For example, although family doctors can be supportive in providing referrals to specialists like IVF clinics or gender-affirming care providers, long wait times for both can be suppressive in accessing desired care (Safer et al., 2016). As well, although there may be individual access to medications and surgery, the broader context of healthcare can be suppressive in the lack of funding and policy to support the 2SLGBTQ community (Tasker & Gato, 2020). This was shown through my participant's discussion where they knew of the long wait times so started their journey two years before they were intending to start a family, and they were restricted in their treatment options if they were to qualify for funding. As well, a recent virtual art exhibition showcasing findings from a study on trans-femme experiences within healthcare settings highlighted the nuances where some people had supportive HCPs that provided access to medications, but HCPs lacked knowledge on the effects that treatments could have on pleasure and reproduction (Giri, 2021).

Again, no individual has the same experiences within the healthcare system; however, it is clear that the system and the providers within it contribute to understandings of who and what is normal. More stories shared by Giri (2021), explore how, when accessing healthcare services, trans people felt as though they had to dress and act a certain way to be perceived as legitimate.

Participants also report withholding certain information from their HCPs as they felt it could affect their ability to access treatment (Giri, 2021). These examples highlight how, although there are more inclusive policies — for example the DSM, same-sex marriage legalization, and IVF access — for the 2SLGBTQ community, many barriers to access continue to exist. As well, although individual HCPs are supportive towards members of the 2SLGBTQ community, they may also face institutional barriers that are more challenging to overcome.

Legislation

Heteronormativity and cisnormativity affect legislation and consequently what is considered normal. Although legislation and policy struggles were not central themes to this research, participants in other studies (from outside Canada) discussed themes that focused more on legislation and policy struggles (Mizielińska & Stasińska, 2019; Tasker & Gato, 2020). Being subject to Canadian legislation along with participants' life stage could contribute to the lack of discussion around challenges with legislation and policy. Location is relevant as it influences social and political context and Canada has specific policy allowing for same-sex union. However, although same-sex unions have been recognized in Canada since 2005, in India, for example, homosexuality was not decriminalized until 2018 (Kidangoor, 2018). As well, although some countries have legalized same-sex marriage, support for reproducing within the 2SLGBTQ community may be less accepted (Appelgren Engström et al., 2018; Weissman, 2017). With this, I found that researchers discussed the intricacies and challenges with adoption, accessibility to assisted reproductive technologies, and marriage and parental rights more so than the participants within my study (Appelgren Engström et al., 2018; Karpman et al., 2018; Mizielińska & Stasińska, 2019; Tasker & Gato, 2020). Shared commonalities discussed coincide with participants' representation, lack of knowledge, and general confusion around legislation aimed

at fertility intentions and family planning for the 2SLGBTQ community. These findings highlight the importance in understanding the impact that social and political context have on legislation, and the impact legislation can have on the family planning experiences of the 2SLGBTQ community.

Financial Implications

As all participants in my study discussed finances related to family planning, it requires further exploration. My participants' conversations may be related to their status as students, and their average age being 24.6 years old. Approximately 70% of college students report feeling financial stress (Lam & Legg, 2018), and both Millennials and Generation Z'ers — those born between 1981-1996 and 1997-present, respectively (Dimock, 2019) — value financial security and have experienced recessions, general economic challenges (The Annie E. Casey Foundation, 2021; YPulse, 2019), and a global pandemic all influencing finances (Interac Corp, 2020; Konish, 2020). Furthermore, as explored in the literature review, many members of the 2SLGBTQ community experience lower pay based on intersections of identities (Waite et al., 2019). For my participants, employment, age, gender and sexual identity may overlap to create additional financial barriers, representing similar findings for other members of the 2SLGBTQ community.

Financial impacts related to assisted reproductive treatment may have been underreported as many of my participants were in the imagining phase, and those that were actioning intentions lived in a province where there was some government funding for assisted reproductive technologies. For those amid fertility treatment, financial barriers can create challenges where members of the 2SLGBTQ community cannot achieve the family they desire. It was challenging to find research articles where the main focus was financial implications including where

financial barriers stopped people from achieving their fertility goals. Most of the information was found from newspaper articles or blog posts of individuals expressing their financial concerns related to fertility (see Longman 2020; Stanton Lee, 2019; Sutton, 2018, for more detail).

Ultimately, the cost of assisted reproductive technologies for the 2SLGBTQ community can create further oppressions where only financially privileged individuals can reproduce (Carroll, 2018). Exploring the financial impact of fertility treatment for members of the 2SLGBTQ community warrants further attention.

Intentionality

Research parallels my findings regarding the intentionality behind the decisions of the 2SLGBTQ community (Lane, 2019; Mizieleńska & Stasińska, 2019; Tasker & Gato, 2020). I did not discuss fertility intentions and family planning with cisgender and heterosexual participants, as it is outside of my study's scope. However, Mizieleńska and Stasińska (2019) argue that members of the 2SLGBTQ community (specifically lesbian women) experience more barriers, oppressions, and intentionality through stereotypes, discrimination and navigating non-normative parenting relationships compared with cisgender and heterosexual couples. Similarly, many participants in my study and on reddit explored the idea that cisgender and heterosexual couples experience less barriers when imagining and actioning their fertility and were also less intentional in their decision making than members of the 2SLGBTQ community. Based on what is considered normal and with what is known about the most valued identities, I suggest that identities that are considered less normal and therefore less valued experience increased intentional decision making.

I consider one's path to fertility intentions as a trail leading through the forest. Heterosexual and cisgender people navigating fertility intentions, whether inclusive of assisted

reproductive technology or not, can experience some barriers and obstacles as they form their family. However, the path is likely very well-travelled with others like them that have navigated similar experiences. As well, once their family is formed, they have successfully navigated the path and come out of the forest into a society where they are well represented. For individuals within the 2SLGBTQ community, the path is less travelled and poorly marked, where they must navigate fallen trees and mud in their way. If they decide to have children, once they are able to access reproductive assistance, the path continues as they face obstacles related to pregnancy, birth, and parenting within normative confines and expectations of society.

Intentional decision-making was not limited to fertility. Participants in my study experienced intentional decisions when going out in public, with public displays of affection, or deciding to dress a certain way for fear of being treated differently. Participants also experienced intentional decision-making when interacting with healthcare systems and deciding what way to be most respectfully and safely treated. Not only does this highlight the impact of heteronormativity and cisnormativity within society, but it also brings to light the transphobia, homophobia, and biphobia that remain rampant within society (Donato, 2020; Government of Canada, 2020; United Church, 2021). The experiences had by members of the 2SLGBTQ community require intentionality in a way that the unencumbered path does not, therefore demonstrating the negative correlated relationship between intentionality and heterosexual or cisgender identity.

Within socialized heteronormative and cisnormative ideals, there is a very narrow idea of what makes someone normal. For some participants, this ideal of normal extends to their intentional decisions and the beliefs behind what makes a “normal family.” For example, one might desire to have two biological children in a partnered relationship — ultimately striving to

fit within the societal expectations of what makes a normal family. For some, this creates an internal conflict regarding if you want to have what society defines as normal, or what one personally defines as normal. Considering that the formation of one's gender and sexual identity often focuses on the historical, biological and social context of one's experiences, a common theme of queer identity theories focuses on feeling different when compared with societal norms (Eliason & Schope, 2007). This internalized feeling that one is different highlights that not only can members of the 2SLGBTQ community feel different but with heteronormativity and cisnormativity as dominant societal ideals, they are also treated differently. Together, internally feeling they are different, and externally being shown they are different highlights why members of the 2SLGBTQ community are intentional about fertility and other behaviours, as they are constantly navigating a society where they do not wholly fit.

Emotional Labour

Intentional decision-making leads to emotional labour. Emotional labour is the “effort, planning, and control needed to express organizationally desired emotion during interpersonal interactions” (Morris & Feldman, 1996, p. 987). We see the emotional labour expended by participants as they navigate systems of oppression, are forced to educate HCPs and members of the public, anticipate and overcome challenges, and make choices to fit within the confines of heteronormative and cisnormative society. Considering that emotions are socially constructed, understood, and thus directed by societal understandings (Morris & Feldman, 1996), existing in a heteronormative and cisnormative society will challenge the experiences an individual faces and increase one's emotional labour.

Berenstain (2016) explores the term *epistemic exploitation*, where those with privilege (for example, HCPs, heterosexual and cisgender people) hold power to exploit emotional labour

from marginalized groups. This exploitation is done by attempting to have the community explain the oppressions they face (Berenstain, 2016). This exploitation was exemplified by participants explaining their situation to HCPs, friends, and family and navigating how they wanted to be seen and witnessed within health care systems and — more broadly — within society. With this, not only do heteronormativity and cisnormativity play a role in the experiences within highly gendered areas of healthcare, the effect of normative ideologies on emotional labour effect the everyday experiences of the 2SLGBTQ community.

Value of Intersectionality

Hierarchies of normal, as previously noted, cause some identities to be oppressed, silenced, and made invisible. This privileging of some identities over others further highlights the value in using an intersectional analysis to explore the different experiences and desires one has. Intersectionality highlights the importance of understanding how some are privileged over others and how deeply entangled the human experience is (Lane, 2019; Mizielińska & Stasińska, 2019). Furthermore, intersectionality allows deeper exploration when understanding the complexities of reproductive justice for the 2SLGBTQ community (Lane, 2019) and integrating the effect that complex social and political factors have on one's experiences (Mizielińska & Stasińska, 2019).

Of note, previous research parallels my findings where intersections of identities, lived experiences, and ideals of normal form fertility intentions — regardless of race, sexuality, gender, and location (Bowling et al., 2019; Karpman et al., 2018). This parallel shows the value in exploring the effects of heteronormativity and cisnormativity using an intersectional framework, as there are many overlapping and intersecting aspects of identity that can create barriers outside of normative identities.

Creating “Normal” Through Representation

Ideals of normal are compounded by a lack of visibility of people outside of normal. Because media influences how we perceive a situation (Philo, 1990), holistic, appropriate and accurate representation of the 2SLGBTQ community is invaluable. At an individual level, media shapes the identities of the 2SLGBTQ community (McInroy & Craig, 2017), and influences the imagining of future identity development (Awan, 2007). This influence means that if there is a limited representation of 2SLGBTQ families, those within the 2SLGBTQ community interested in becoming parents may not imagine this as a future possibility. Specific to fertility intentions and family planning, Appelgren Engström et al. (2018), found that fertility clinics only show heteronormative and cisnormative images, paralleling what participants in my study discussed. More broadly, representation within media of the 2SLGBTQ community also lacks an intersectional perspective, where generally affluent gay males are most prominently shown in media, while trans, non-binary people who are diverse races, cultures, and socioeconomic status lack representation (McInroy & Craig, 2017).

Additionally, similar to what my participants experienced, members of the 2SLGBTQ community are often represented in media as villains, comedic relief, or victims of violence (McInroy & Craig, 2017). This representation affects both how individuals see themselves (as my participants explored) and how those outside of the 2SLGBTQ community (like HCPs) view the 2SLGBTQ community (Philo, 1990). Ultimately, media representation affects an internal sense of self-identity and possible future identity of those within the 2SLGBTQ community and portrays the community in a specific way. Because of this, representation needs to be intersectional, inclusive, and accurate for positive identity development and treatment.

The Paradox of Value

The above topics emphasize the complex paradox of societal expectations where reproducing is valued but reproducing as a member of the 2SLGBTQ community is devalued. As all my participants were interested in parenting in one way or another, there was little discussion on being child-free. This interest in parenting parallels the societal value of reproduction that extends to expectations of the 2SLGBTQ community. Mamo and Alston-Stepnitz (2015) highlight this paradoxical catch-22, where members of the 2SLGBTQ community are expected to procreate; however, they experience a multitude of constraints politically, economically and culturally. Similar to my participant criticizing the “gay ideal family structure” (through the notion of fitting in via reproducing), the 2SLGBTQ community may be encouraged to fit in within normative ideals and societal expectations and is also heavily barriered in their ability to do so (Carroll, 2018; Mamo & Alston-Stepnitz, 2015). This paradox further explores the challenges that members of the 2SLGBTQ community face. Many of the dominant discourses around family are steeped in normative beliefs to make 2SLGBTQ families more normal, ultimately further isolating and challenging those with intersections of identities (Carroll, 2018). This paradox highlights how entangled societal understandings and healthcare experiences are, and the importance in understanding the complexities when moving forward to make healthcare experiences better for the 2SLGBTQ community.

When one’s identity is considered outside of normal, they exist as “other” within a society. Feelings of other can create an increase in intentional decision making and emotional labor for the 2SLGBTQ community. As normative reproduction is societally valued, those within the 2SLGBTQ community experience challenges when imagining and actioning their fertility intentions and family plans. Heteronormativity and cisnormativity are dominant ideologies

within healthcare systems and affect the experiences of the 2SLGBTQ community when accessing all areas of healthcare. In healthcare settings, policies and practices perpetuate heteronormativity and cisnormativity. HCPs working in these systems then perpetuate these ideologies, as workplace culture is highly influenced by societal norms (Sharp et al., 2018). Societal norms are then perpetuated within healthcare workplaces, which leads to difficulty in changing workplace culture (Sharp et al., 2018). Within these settings, HCPs, such as nurses, also perpetuate normative ideologies by existing in a culture of neutrality where the dominant mentality of treating everyone the same equals treating everyone fairly (Beagan et al., 2012; McGibbon & Lukeman, 2019). Nurses have a responsibility to challenge the normative ideologies that are affecting the healthcare experiences of the 2SLGBTQ community.

Implications for Nursing

Although it can be challenging in highly gender-specific healthcare areas, nurses may also create invisibilities within health care systems by ignoring gender and sexuality and forcing neutrality, ultimately making others ignore or hide their authentic selves. 2SLGBTQ community is at risk for many non-gendered health concerns and consequently exemplifies this invisibility. Although nurses are mandated toward social justice and health equity (Canadian Nurses Association, 2010), some believe that to treat everyone equally we must treat everyone the same (Beagan et al., 2012; Eliason et al., 2010), and it is time that we shift this narrative.

From my experience working as a nurse at a fertility clinic, the findings from this study parallel what patients experienced at my former workplace. In a management position, a large part of my job was speaking with patients about their concerns. We often found that patients that were members of the 2SLGBTQ community would travel to clinics out of province that were known to be more accepting and inclusive. When 2SLGBTQ patients would express concerns

about the care they received, our common reply was “we treat everyone the same.” When I would speak directly with patients about their concerns, they would explain the heteronormative and cisnormative protocols and policies that were in place, feeling that they fit outside of the box, and how each time they spoke with a different staff member, they had to explain that they were “different.” At the time, I knew that something did not feel quite right, but I did not have the language, understanding or voice to challenge the normative policy and culture within the clinic.

Nurses have a history of being silenced and depoliticized (Buck-Mcfadyen & Macdonnell, 2017). Nursing silence is due to complex social and historical factors, including the medical hierarchy, where nurses feel as though they cannot challenge the status quo based on the patriarchal healthcare system (Dong & Temple, 2011; Weitzel et al., 2020). As nurses, our moral and ethical responsibility is to advocate for safer and more inclusive spaces, education, and practice for our patients (Weitzel et al., 2020). Because of our trustworthy position within society (Gaines, 2021) and our foundational connection to social justice (Canadian Nurses Association [CNA], 2009), we are primed to take action and make changes that have a positive influence on the health of our patients. Taking action through activism involves using our trusted societal position to address health inequities (Florell, 2021). Taking action is an essential nursing practice component if Registered Nurses want to stay relevant within healthcare systems' changing political landscape (Florell, 2021). Members of the 2SLGBTQ community actively experience discrimination at the hands of the health care system, and nursing is central to making a change to increase visibility, representation, inclusion, and safe care to improve the health for this community.

In speaking with participants when imagining safe and inclusive healthcare spaces, it is unlikely there will be one single action that can make healthcare spaces sweepingly safe for everyone all of the time, especially considering the intersections of identities. This research implicates nurses at an individual level, in our practice setting, and nursing education. Although the golden rule dictates to treat everyone how you would want to be treated (arguably the same), the nursing profession may benefit from a shift to start practicing the platinum rule: treating others how they want to be treated (Economy, 2016). Shifting to a mentality of treating others how they want to be treated can create space to open dialogue between the patient and the nurse to step away from the idea of sameness and neutrality. This dialogue can create more opportunities to share power by valuing and amplifying the voices of the 2SLGBTQ community.

Call to Action

In this study, participants explored the challenges within the current healthcare system. They discussed how there is no easy, one-size-fits-all effort to create safe and inclusive spaces for every individual as there are many complexities within identities. The following acts as a call to action based on conversations with participants, my experience as a nurse, and literature from academic sources and voices within the 2SLGBTQ community. From my experience with this research project through speaking with participants, colleagues, peers, and friends, I found a lack of ability to take action; people feel paralyzed in fear that they may do the wrong thing. Personally, when learning more about the history of the 2SLGBTQ community within society and healthcare systems, I felt urged to take action but did not know where to start. However, the risk of doing nothing to try to improve care for these populations is also undesirable.

My goal is to continue the conversation around actions that nurses can take to open up the discussion, challenge feelings of fragility, and be more comfortable with the uncomfortable. If

we never challenge, we will never change. Throughout all levels of nursing practice, we must amplify the voices of the 2SLGBTQ community. Although empirical evidence on the outcomes of these actions is limited, we must be willing to try new things. I acknowledge that these calls are not exhaustive and may risk not being beneficial for everyone; however, as these conversations are not new, I wholly believe that we need to start taking action to change.

Individual Level

At the individual level, nurses can educate themselves about the 2SLGBTQ community. Community organizations, such as OUTSaskatoon, have a plethora of information about sexual and gender orientations, with some resources specific for HCPs (see OUTSaskatoon, 2021, for more detail). Additionally, Saskatchewan Prevention Institute has many recorded webinars — for example, trans and non-binary sexual health and pregnancy and human sexuality 101 (see Mason, N., 2021; Clark, M., 2021, for more detail). Additionally, there is a free, interactive course related to sexual orientation and gender identity that targets educating nurses (see CanSim, n.d, for more detail). As members of the 2SLGBTQ community constantly expend emotional labour educating HCPs on what their identities mean versus obtaining the care and treatment they need, a basic understanding of gender and sexuality is invaluable (Boccomino, 2020). Additionally, Saad (2020) identified that “you cannot dismantle what you cannot see, and you cannot challenge what you don’t understand” (pp. 244-245). As HCPs, we need to acknowledge and understand that differences exist, that heteronormativity and cisnormativity are prevalent, examine and reflect on how we may be incidentally perpetuating normative ideologies, then provide appropriate care to our 2SLGBTQ patients.

In Practice

In our practice, we can use inclusive language and advocate for staff to have pronouns visible on name tags if they are comfortable and for forms to become gender-neutral (Boccomino, 2020; Brusie, 2020). Again, patients continually having to explain or validate their identity is extremely emotionally laborious and asking pronouns has been a suggestions from the community that can help to mitigate this continual explanation (Boccomino, 2020).

Nurses can also create journal clubs or interest groups to understand the effects that normative ideologies have on the 2SLGBTQ community. Journal clubs are effective in improving understandings of different topics and can be helpful when implementing changes in practice (Häggman-Laitila et al., 2016). The Rainbow Nursing Interest group within the Registered Nurses Association of Ontario (RNAO) is an excellent example of nurses coming together to further understand the oppressions faced by the 2SLGBTQ community and acknowledge the impact of intersectional oppressions this group works to advance inclusivity (RNAO, 2020). Specifically, they provided recommendations to the Standing Committee's Report on Health advocating for 2SLGBTQ education for HCPs and increasing funding for health coverage for the 2SLGBTQ community (RNAO, 2020).

Practicing in a trauma-informed manner is imperative for working with diverse populations (Fleishman et al., 2019). Nurses can easily incorporate aspects of trauma-informed care into their practice by introducing themselves and their role, being aware of their body language, and providing expectations for appointments and services (Fleishman et al., 2019). As trauma-informed care was introduced in 2005, the literature surrounding the efficacy of trauma-informed care is lacking, but early indicators suggest that it can be effective in reducing re-traumatization when working with a variety of populations (Barajas & Martinez, 2020).

Within nursing practice settings, we can speak with our managers and colleagues and share resources about the 2SLGBTQ community. We can write to our regulatory bodies to advocate for cultural humility, trauma-informed care, and for learning about the 2SLGBTQ community to be mandatory within nursing education or yearly practice competencies. As activism can take on many forms, including policy change, lobbying, educating and creating coalitions (Florell, 2021), nurses have many options within their practice to make changes for the 2SLGBTQ community.

In Education

Within nursing education, we have the opportunity to educate new nurses on the importance of cultural humility and trauma-informed care within our practice. Considering the intersections of identities within the 2SLGBTQ community, educating nurses on singular identities is not enough; we must teach ways in which nurses can alter their practice to benefit the care of all patients. Cultural humility involves an awareness of the power imbalances that exist and seeking a shift in one's way of being in the world (Foronda et al., 2016). Cultural humility involves nurses practicing in a way where we listen to our patients' voices, practice critical self-reflection, self-awareness, and egolessness (Foronda et al., 2016). Similar to cultural humility, we can educate nurses on providing culturally safe care, which acknowledges power dynamics, engaging in reflective practice, and giving the patient space to decide if the interaction is safe (Curtis et al., 2019). Health equity and cultural safety are correlated as they encourage privileging the patient's voice; reflecting on personal beliefs, understanding different cultures; and holding ourselves accountable as HCPs (Curtis et al., 2019). We can also shift curriculums to educate nursing students on the importance of trauma-informed practice, considering that some healthcare services can be re-traumatizing for people (Fleishman et al., 2019). Trauma-informed

care is rooted in safety, transparency, empowerment, and responsiveness to different cultures (Fleishman et al., 2019).

Steps Towards Decolonizing Nursing

The nursing profession has a complex history. McGibbon et al. (2014), argues that the nursing profession has long been shaped by positivism, apoliticism, Eurocentrism, patriarchy, and White supremacy. This history may start with early nursing theories constructing White-centric models of health that shape nursing practice and promote neutrality within the profession (McGibbon et al., 2014). Decolonizing nursing practice includes critical-self-reflection, questioning dominant ideologies, and amplifying unheard voices to focus on those that have been marginalized due to structural systems of inequity (Chandanabhumma & Narasimhan, 2019). This shift may also involve educating nurses on public policy, planning, implementation and evaluation to move towards understanding how to influence change at a systemic level (McGibbon et al., 2014).

Nursing may be challenged in its ability to make significant and meaningful change. These challenges may stem from gender norms and job constraints, including a culture of efficiency, strict boundaries for educational curriculum, cutbacks within workplaces (Buck-Mcfadyen & Macdonnell, 2017) and hierarchies within medical professions (Dong & Temple, 2011). Additionally, nurses exist as oppressed oppressors, where we are oppressed through feelings of overwork and under pay, horizontal violence and hierarchies (Rooddehghan et al., 2015). We simultaneously act as oppressors where we can use our power to withhold care and perpetuate neutrality when treating patients (Rooddehghan et al., 2015). Similarly, if change occurs, we may see a disconnect between theory and practice. For example, a recent panel hosted by Saskatchewan First Nations & Metis Health Research Network invited healthcare and policy

leaders to discuss racism in healthcare. In this panel, the executive director of Saskatchewan Registered Nurses Association, Cindy Smith, highlighted that, although nursing education in Saskatchewan has shifted to include concepts of health equity and social justice, we are not seeing these concepts translated into practice (Smith, 2021).

These examples show that there are many complex and nuanced factors that come with making change and taking action. As I understand it, this is not a linear, straightforward or basic task as achieving equity is highly complex and the nursing profession faces many internal challenges. Perhaps we start with asking the right questions, recognizing the nursing role in perpetuating oppression and the power that nurses hold to take action. Nurses can lead the change, whether related to the 2SLGBTQ community seeking to start a family or other oppressed groups seeking healthcare services.

Limitations

The COVID-19 pandemic limited this study as it was forced to change from the original plan and move away from in-person meetings. This study was also limited in its diversity of participants, where although there was representation from different races, cultures, gender and sexual identities, the majority of participants were White students and no participant discussed having disabilities. The study findings are not generalizable to the greater public considering the nature of qualitative research, the sample size, study participants and location. However, it does provide an exploration of experiences. Additionally, the multiple identities within the 2SLGBTQ community could have limited original results in the initial review of the literature.

Knowledge Translation

My knowledge translation plan is trifold and encompasses action within academia, for the 2SLGBTQ community and for HCPs. Within academia, I plan to publish my literature review

and my findings. I will also aim to attend conferences and present at conferences. For example, my abstract has been accepted to present at the University of Saskatchewan's College of Nursing Research and Scholarship Day and at the Community Health Nurses of Canada conference. With the community, I will make a brief and easily understandable summary to send to my participants and invite feedback. Secondly, I plan to meet with Jack Saddleback at OUTSaskatoon and Heather Hale with Saskatoon Sexual Health to discuss findings and next steps. I will create something (for example, an infographic) to provide to the community, based on their desires. Some options include the development of a flow chart for fertility options based on what gametes are available, or a link to supports where people can find information. Lastly, I will reach out to my HCP connections at the fertility clinic I was previously employed at and discuss a presentation of my findings. I will also reach out to Aurora Fertility in Saskatoon and see if I can present and discuss findings and options moving forward. I will leverage my position as someone with experience with fertility when working with clinics and HCPs when sharing my findings and collaborate with what resources they may need or desire.

In Conclusion

The experiences of the 2SLGBTQ community related to fertility intentions and family planning are nuanced, complex, and influenced by a variety of experiences. Historical, societal and medical understandings of what is normal dictate these experiences and create additional barriers for the 2SLGBTQ community. As such, barriers exist not only in highly gendered areas of healthcare but affect the everyday lived experiences outside of healthcare. The decisions made by the 2SLGBTQ community are more intentional than those outside the community and thus require additional emotional labour expenditure in an area that is already emotionally charged. An intersectional lens on fertility intentions is imperative when exploring experiences, as

additional barriers exist for those depending on race, class, disability on top of sexuality and gender. As nurses, it is imperative that we understand the history of the medical system, the barriers this community faces, and our role in changing health disparities. We can start by reflecting on our biases and seek critical education related to sexual and gender minorities within healthcare systems. Incorporating a critical social justice lens within our practice, education, and research can challenge systems of oppression, root causes of inequities and begin to action change within our systems and profession. Taking seemingly small steps can lead to sweeping change and must be deeply embedded within our practice. Ending with the sentiment shared by James Baldwin in his unpublished memoir *Remember this House*, “not everything that is faced can be changed, but nothing can be changed until it is faced.”

References

American Psychiatric Association. (2013). *Gender dysphoria*.

<https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets>

Anderson, K. E. (2015). Ask me anything: what is Reddit? *Library Hi Tech News*, 32(5), 8-11.

<https://doi.org/10.1108/LHTN-03-2015-0018>

Angelino, A., Evans-Campbell, T., & Duran, B. (2020). Assessing health provider perspectives regarding barriers American Indian/Alaska Native transgender and Two-Spirit youth face accessing healthcare. *Journal of Racial and Ethnic Health Disparities*.

<https://doi.org/10.1007/s40615-019-00693-7>

Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C., & Almqvist, A.-L. (2018).

Mothers in same-sex relationships describe the process of forming a family as a stressful journey in a heteronormative world: A Swedish grounded theory study. *Maternal and Child Health Journal*, 22(10), 1444-1450. <https://doi.org/10.1007/s10995-018-2525-y>

Ard, K., L., & Makadon, H. (2016). *Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities*.

<https://www.lgbthealtheducation.org/publication/improving-the-health-care-of-lesbian-gay-bisexual-and-transgender-lgbt-people-understanding-and-eliminating-health-disparities/>

Awan, F. (2007). *Young people, identity and the media: A study of conceptions of self-identity among youth in Southern England* [Bournemouth University].

Baldwin, J. (n.d). Remember this house.

- Barajas, L., & Martinez, G. (2020). Effectiveness of trauma-informed practice. *Symposium on Undergraduate Research and Creative Expression*
<https://scholar.valpo.edu/cgi/viewcontent.cgi?article=1930&context=cus>
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *Qualitative Report*, 13(4), 544.
<https://nsuworks.nova.edu/tqr/vol13/iss4/2/>
- Beagan, B., Fredericks, E., & Goldberg, L. (2012). Nurses' work with LGBTQ patients: "They're just like everybody else, so what's the difference?". *The Canadian Journal of Nursing Research*, 44, 44-63. <https://pubmed.ncbi.nlm.nih.gov/23156191/>
- Beasley, C. (2005). *Gender & sexuality: Critical theories, critical thinkers*. Sage.
- Berenstain, N. (2016). Epistemic exploitation. *Ergo, an Open Access Journal of Philosophy*, 3(20190619). <https://doi.org/10.3998/ergo.12405314.0003.022>
- Berkowitz, D. (2011). "It was the Cadillac of adoption agencies": Intersections of social class, race, and sexuality in gay men's adoption narratives. *Journal of GLBT Family Studies*, 7(1-2), 109-131. <https://doi.org/10.1080/1550428X.2011.537227>
- Betker, C., MacDonald, M., Hill, M., & Kirk, M. (2015). Theoretical foundations of community health nursing. In L. L. Stamler, L. Yiu, & A. Dosani (Eds.), *Community health nursing: a Canadian perspective* (4th ed., pp. 101-134). Pearson.
- Boccomino, H. (2020). *Five ways to be an LGBTQ patient ally*.
<https://www.apta.org/article/2020/07/21/five-ways-to-be-an-lgbtq-patient-ally>
- Bowling, J., Simmons, M., Dodge, B., Sundarraman, V., Lakshmi, B., Dharuman, S. T., & Herbenick, D. (2019). Family formation goals among sexual and gender minority

- individuals in urban India. *Studies in Family Planning*, 50(4), 357-373.
<https://doi.org/10.1111/sifp.12102>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*(ahead-of-print), 1-25.
<https://doi.org/10.1080/14780887.2020.1769238>
- Brotman, S., Ryan, B., Jalbert, Y., & Rowe, B. (2002). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and two-spirit people. *Journal of Health & Social Policy*, 15(1), 1-29. https://doi.org/10.1300/J045v15n01_01
- Brown, C., Frohard-Dourlent, H., Wood, B. A., Saewyc, E., Eisenberg, M. E., & Porta, C. M. (2019). "It makes such a difference": An examination of how LGBTQ youth talk about personal gender pronouns. *Journal of the American Association of Nurse Practitioners*.
<https://doi.org/10.1097/jxx.0000000000000217>
- Brusie, C. (2020). *10 tips for caring for LGBTQ patients*. <https://nurse.org/articles/culturally-competent-healthcare-for-LGBTQ-patients/>
- Buck-Mcfadyen, E., & Macdonnell, J. (2017). Contested practice: Political activism in nursing and implications for nursing Education. *International Journal of Nursing Education Scholarship*, 14(1). <https://doi.org/10.1515/ijnes-2016-0026>
- Canada Public Health Association. (n.d). *History of family planning in Canada*.
<https://www.cpha.ca/history-family-planning-canada>
- Canadian Blood Services. (n.d). *Men who have sex with men*. <https://www.blood.ca/en/blood/am-i-eligible/men-who-have-sex-men>

Canadian Nurses Association. (2010). Social Justice... a means to an end, an end in itself.

https://www.cna-aicc.ca/~media/cna/page-content/pdf-en/social_justice_2010_e.pdf

Canadian Nurses Association [CNA]. (2009). Ethics in practice for Registered Nurses.

Canales, M. (2010). Othering: Difference understood??: A 10-Year analysis and critique of the nursing literature. *Advances in Nursing Science*, 33(1), 15-34.

<https://doi.org/10.1097/ANS.0b013e3181c9e119>

CanSim. (n.d). *Sexual orientation gender identity nursing education*. <http://www.can-sim.ca/games/courses/sogi-nursing-certification/>

Carroll, M. (2018). Gay fathers on the margins: Race, class, marital status, and pathway to parenthood. *Family Relations*, 67(1), 104-117.

<https://doi.org/http://dx.doi.org/10.1111/fare.12300>

Challacombe, L. (2020). *HIV epidemiology in Canada*. <https://www.catie.ca/en/fact-sheets/epidemiology/epidemiology-hiv->

[canada?utm_source=google&utm_medium=cpc&utm_content=en&utm_campaign=wad+hiv+stats#hivstatistics](https://www.catie.ca/en/fact-sheets/epidemiology/epidemiology-hiv-canada?utm_source=google&utm_medium=cpc&utm_content=en&utm_campaign=wad+hiv+stats#hivstatistics)

Chandanabhumma, P. P., & Narasimhan, S. (2019). Towards health equity and social justice: An applied framework of decolonization in health promotion. *Health Promotion*

International, 35(4), 831-840. <https://doi.org/10.1093/heapro/daz053>

Clark, B. A., Veale, J. F., Greyson, D., & Saewyc, E. (2018). Primary care access and foregone care: A survey of transgender adolescents and young adults. *Family Practice*, 35(3), 302-

306. <https://doi.org/10.1093/fampra/cmz112>

Clark, M. (2021, February 4). Trans and non-binary sexual health and pregnancy [webinar]. *Saskatchewan Prevention Institute*.

- Community Health Nurses of Canada. (2020). The Canadian community health nursing standards of practice. In L. L. Stamler, L. Yiu, A. Dosani, J. Etowa, & C. Van Daalen-Smith (Eds.), *Community health nursing: A Canadian perspective* (5th ed., pp. 610-614). Pearson.
- Connell, R. (2012). Transsexual women and feminist thought: Toward new understanding and new politics. *Signs*, 37(4), 857-881. <https://doi.org/10.1086/664478>
- Crenshaw, K. (2016, March, 14). *On intersectionality [video]* London UK. <https://www.youtube.com/watch?v=-DW4HLgYPIA>
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International journal for equity in health*, 18(1), 174. <https://doi.org/10.1186/s12939-019-1082-3>
- Dahl, U. (2018). Becoming fertile in the land of organic milk: Lesbian and queer reproductions of femininity and motherhood in Sweden. *Sexualities*, 21(7), 1021-1038. <https://doi.org/10.1177/1363460717718509>
- Debnath, K. (2017). LGBT identity: The illustration of “Othering” in India. *Sexuality, Gender & Policy*, 1(1), 89-100. <https://doi.org/10.18278/sgp.1.1.6>
- Denier, N., & Waite, S. (2019). Sexual orientation at work: Documenting and understanding wage inequality. *Sociology Compass*, 13(4). <https://doi.org/10.1111/soc4.12667>
- Dhillon, N., Oliffe, J. L., Kelly, M. T., & Krist, J. (2020). Bridging barriers to cervical cancer screening in transgender men: A scoping review. *American Journal of Men's Health*, 14(3), 1-10. <https://doi.org/10.1177/1557988320925691>

Dimock, M. (2019). *Defining generations: Where Millennials end and Generation Z begins.*

<https://www.pewresearch.org/fact-tank/2019/01/17/where-millennials-end-and-generation-z-begins/>

Donato, A. (2020). Transphobia comes in many forms. Here's how to challenge some.

Huffington Post. https://www.huffingtonpost.ca/entry/transgender-international-day-against-transphobia_ca_5ebec20dc5b6925339399bd5

Dong, D., & Temple, B. (2011). Oppression: a concept analysis and implications for nurses and nursing. *Nurs Forum*, 46(3), 169-176. <https://doi.org/10.1111/j.1744-6198.2011.00228.x>

Dorsen, C., & Van Devanter, N. (2016). Open arms, conflicted hearts: Nurse-practitioner's attitudes towards working with lesbian, gay and bisexual patients. *Journal of Clinical Nursing*, 25(23-24), 3716-3727. <https://doi.org/10.1111/jocn.13464>

Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry* 24, 568-577. <https://doi.org/10.3109/09540261.2012.741575>

Economy, P. (2016, March 17). How the platinum rule trumps the golden rule every time.

Inc.com. <https://www.inc.com/peter-economy/how-the-platinum-rule-trumps-the-golden-rule-every-time.html>

Eisenberg, M. E., McMorris, B. J., Rider, G. N., Gower, A. L., & Coleman, E. (2020). "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health & Social Care in the Community*, 28(3), 1082-1089. <https://doi.org/10.1111/hsc.12941>

- Elertson, K., & McNiel, P. L. (2020). Answering the call: Educating future nurses on LGBTQ healthcare. *Journal of Homosexuality*, 1-12.
<https://doi.org/10.1080/00918369.2020.1734376>
- Eliason, M. J. (2017). The gender binary in nursing. *Nursing Inquiry*, 24(1), 1-3.
<https://doi.org/10.1111/nin.12176>
- Eliason, M. J., & Chinn, P. L. (2018). *LGBTQ cultures: What health care professionals need to know about sexual and gender diversity* (3rd ed.). Wolters Kluwer.
- Eliason, M. J., Dibble, S., & DeJoseph, J. (2010). Nursing's silence on lesbian, gay, bisexual, and transgender issues: The need for emancipatory efforts. *Advances in Nursing Science*, 33(3), 206-218. <https://doi.org/10.1097/ANS.0b013e3181e63e49>
- Eliason, M. J., Dibble, S. L., DeJoseph, J., & Chinn, P. L. (2012). LGBTQ issues in nursing. *Nursing made Incredibly Easy*, 10(2).
https://journals.lww.com/nursingmadeincrediblyeasy/Fulltext/2012/03000/LGBTQ_issues_in_nursing.2.aspx
- Eliason, M. J., & Schope, R. (2007). Shifting sands or solid foundation? Lesbian, gay, bisexual, and transgender identity formation. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 3-26). SpringerLink.
- Ellis, S. A., Wojnar, D. M., & Pettinato, M. (2015). Conception, pregnancy, and birth experiences of male and gender variant gestational parents: It's how we could have a family. *Journal of Midwifery & Women's Health*, 60(1), 62-69.
<https://doi.org/10.1111/jmwh.12213>

Fausto-Sterling, A. (2000). The five sexes, revisited. *The Sciences*, 40(4), 18-23.

<https://doi.org/10.1002/j.2326-1951.2000.tb03504.x>

Few-Demo, A. L. (2014). Intersectionality as the “new” critical approach in feminist family studies: Evolving racial/ethnic feminisms and critical race theories. *Journal of Family Theory & Review*, 6(2), 169-183. <https://doi.org/10.1111/jftr.12039>

Fileff, M. (2012). Hospital visitation: The forgotten gay rights struggle. *The John Marshall Law Review* 45, 939. <http://repository.jmls.edu/lawreview/vol45/iss3/10>

Fleishman, J., Kamsky, H., & Sundborg, S. (2019). Trauma-informed nursing practice. *Online Journal of Issues in Nursing*, 24(2), 1-9. <https://doi.org/10.3912/OJIN.Vol24No02Man03>

Florell, M. C. (2021). Concept analysis of nursing activism. *Nursing Forum*, 56(1), 134-140. <https://doi.org/10.1111/nuf.12502>

Foronda, C., Baptiste, D.-L., Reinholdt, M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, 27(3), 210. <https://doi.org/10.1177/1043659615592677>

Foucault, M. (1978). *The history of sexuality* (1st American ed.).

Fredericks, E., Harbin, A., & Baker, K. (2017). Being (in)visible in the clinic: A qualitative study of queer, lesbian, and bisexual women's health care experiences in Eastern Canada. *Health Care for Women International*, 38(4), 394-408. <https://doi.org/10.1080/07399332.2016.1213264>

Gaines, K. (2021). *Nurses ranked most trusted profession 19 years in a row*. <https://nurse.org/articles/nursing-ranked-most-honest-profession/>

Giri, D. (2021). TRANSTORIES: A virtual art exhibit. *Wixsite*. <https://transtories2021.wixsite.com/website>

- Goldberg, A. E., & Sweeney, K. K. (2019). LGBTQ parent families. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Foundations, methods, and contemporary issues across the lifespan., Vol. 1.* (pp. 743-760). American Psychological Association.
<https://doi.org/10.1037/0000099-041>
- Government of Canada. (2019). Sexual and reproductive health and rights.
https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/global_health-sante_mondiale/reproductive-reproductifs.aspx?lang=eng
- Government of Canada. (2020). *The human rights of lesbian, gay, bisexual, transgender, queer, 2-spirit and intersex persons.* https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/human_rights-droits_homme/rights_lgbti-droits_lgbti.aspx?lang=eng
- Hafford-Letchfield, T., Cocker, C., Rutter, D., Tinarwo, M., McCormack, K., & Manning, R. (2019). What do we know about transgender parenting?: Findings from a systematic review. *Health & Social Care in the Community*, 27(5), 1111-1125.
<https://doi.org/10.1111/hsc.12759>
- Häggman-Laitila, A., Mattila, L. R., & Melender, H. L. (2016). A systematic review of journal clubs for nurses. *Worldviews on Evidence-Based Nursing*, 13(2), 163-171.
<https://doi.org/10.1111/wvn.12131>
- Hammack, P. L., Frost, D. M., & Hughes, S. D. (2019). Queer intimacies: A new paradigm for the study of relationship diversity. *The Journal of Sex Research*, 56, 556-592.
<https://doi.org/10.1080/00224499.2018.1531281>

- Hankivsky, O., Doyal, L., Einstein, G., Kelly, U., Shim, J., Weber, L., & Repta, R. (2017). The odd couple: Using biomedical and intersectional approaches to address health inequities. *Global health action*, 10(sup2). <https://doi.org/10.1080/16549716.2017.1326686>
- Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum: Qualitative Social Research*, 18(1).
<https://doi.org/10.17169/fqs-18.1.2655>
- Hicks, S. (2006). Maternal men-perverts and deviants? Making sense of gay men as foster carers and adopters. *Journal of GLBT Family Studies*, 2(1), 93-114.
https://doi.org/10.1300/J461v02n01_05
- Hird, M. (2000). Gender's nature: Intersexuality, transsexualism and the 'sex'/'gender' binary. *Feminist Theory*, 1(3), 347-364. <https://doi.org/10.1177/146470010000100305>
- Holmes, D., & Gagnon, M. (2018). Power, discourse, and resistance: Poststructuralist influences in nursing. *Nursing Philosophy*, 19(1), n/a-n/a. <https://doi.org/10.1111/nup.12200>
- Hunt, S. (2016). *An introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Center for Aboriginal Health.
- Interac Corp. (2020). *Half of Gen Z and Millennial Canadians are more concerned about managing their finances amid COVID-19*. <https://www.newswire.ca/news-releases/half-of-gen-z-and-millennial-canadians-are-more-concerned-about-managing-their-finances-amid-covid-19-825242612.html>
- Issa, O. (2019, June 16). A place in the circle: 2-Spirit people seek visibility and supports. *CBC*.
<https://www.cbc.ca/news/canada/saskatoon/two-spirit-people-marginalized-1.5172812>
- James-Abra, S., Tarasoff, L. A., Green, D., Epstein, R., Anderson, S., Marvel, S., Steele, L. S., & Ross, L. E. (2015). Trans people's experiences with assisted reproduction services: A

- qualitative study. *Human Reproduction*, 30(6), 1365-1374.
<https://doi.org/10.1093/humrep/dev087>
- Karpman, H. E., Ruppel, E. H., & Torres, M. (2018). “It wasn't feasible for us”: Queer Women of Color navigating family formation. *Family Relations*, 67(1), 118-131.
<https://doi.org/10.1111/fare.12303>
- Kidangoor, A. (2018, September 6). India's Supreme Court decriminalizes homosexuality in a historic ruling for the LGBTQ community. *Time*. <https://time.com/5388231/india-decriminalizes-homosexuality-section-377/>
- Klein, D. A., Berry-Bibee, E. N., Keglovitz Baker, K., Malcolm, N. M., Rollison, J. M., & Frederiksen, B. N. (2018). Providing quality family planning services to LGBTQIA individuals: A systematic review. *Contraception*, 97(5), 378-391.
<https://doi.org/https://doi.org/10.1016/j.contraception.2017.12.016>
- Klein, D. A., Malcolm, N. M., Berry-Bibee, E. N., Paradise, S. L., Coulter, J. S., Keglovitz Baker, K., Schvey, N. A., Rollison, J. M., & Frederiksen, B. N. (2018). Quality primary care and family planning services for LGBT clients: A comprehensive review of clinical guidelines. *LGBT Health*, 5(3), 153-170. <https://doi.org/10.1089/lgbt.2017.0213>
- Konish, L. (2020, August, 31). Young workers at risk of financial exhaustion due to coronavirus pandemic. *CNBC*. <https://www.cnbc.com/2020/08/31/young-workers-at-risk-of-financial-exhaustion-due-to-coronavirus-pandemic.html>
- Lam, C., & Legg, E. (2018). Financial stress, social supports, gender, and anxiety during college: A stress-buffering perspective. *Counseling Psychologist*, 46(7), 846-869.
<https://doi.org/10.1177/0011000018806687>

- Lane, J. (2019). Anti-Heteropatriarchal reproductive justice. *Women's studies*, 48(8), 882-899.
<https://doi.org/10.1080/00497878.2019.1676748>
- Laqueur, T. W. (1992). *Making sex: Body and gender from the Greeks to Freud*. Harvard University Press. <http://0-hdl.handle.net.aupac.lib.athabascau.ca/2027/heh.31961>
- Lim, F. A., Brown, D. V., & Justin Kim, S. M. (2014). Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: A review of best practices. *The American journal of nursing*, 114(6), 24.
<https://doi.org/10.1097/01.NAJ.0000450423.89759.36>
- Lim, F. A., & Hsu, R. (2016). Nursing students' attitudes toward lesbian, gay, bisexual, and transgender persons: An integrative review. *Nursing Education Perspectives*, 37(3), 144-152. <https://doi.org/10.1097/01.NEP.0000000000000004>
- Lindroth, M. (2016). 'Competent persons who can treat you with competence, as simple as that' - An interview study with transgender people on their experiences of meeting health care professionals. *Journal of Clinical Nursing*, 25(23-24), 3511-3521.
<https://doi.org/10.1111/jocn.13384>
- Longman, M. (2020, June 15). The hidden costs of starting a family when queer. *Refinery 29*.
<https://www.refinery29.com/en-ca/2020/06/9863868/gay-couples-adoption-ivf-cost-becoming-parents>
- Lyons, T., Krüsi, A., Pierre, L., Smith, A., Small, W., & Shannon, K. (2016). Experiences of trans women and Two-Spirit Persons accessing women-specific health and housing services in a downtown neighborhood of Vancouver, Canada. *LGBT Health*, 3(5), 373-378. <https://doi.org/10.1089/lgbt.2016.0060>

- Mamo, L., & Alston-Stepnitz, E. (2015). Queer intimacies and structural inequalities: New directions in stratified reproduction. *Journal of Family Issues*, 36(4), 519.
<https://doi.org/10.1177/0192513X14563796>
- Manning, W., Fetto, M., & Lamidi, E. (2014). Child well-being in same-sex parent families: Review of research prepared for American Sociological Association Amicus Brief. *Population Research and Policy Review*, 33(4), 485-502. <https://doi.org/10.1007/s11113-014-9329-6>
- Manzer, D., O'Sullivan, L. F., & Doucet, S. (2018). Myths, misunderstandings, and missing information: Experiences of nurse practitioners providing primary care to lesbian, gay, bisexual, and transgender patients. *The Canadian Journal of Human Sexuality*, 27(2), 157-170. <https://doi.org/10.3138/cjhs.2018-0017>
- Mason, N. (2021, February 9). Teaching sex-ed: Human sexuality 101 [webinar]. *Saskatchewan Prevention Institute*. <https://skprevention.ca/event/teaching-sex-ed-human-sexuality-101/>
- Mayan, M. J. (2009). *Essentials of qualitative inquiry*. Left Coast Press.
- McGibbon, E., & Lukeman, S. (2019). Critical social justice: The moral imperative for critical perspectives in nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, 1(1), 3-12. <https://doi.org/10.25071/2291-5796.21>
- McGibbon, E., Mulaudzi, F. M., Didham, P., Barton, S., & Sochan, A. (2014). Toward decolonizing nursing: The colonization of nursing and strategies for increasing the counter-narrative. *Nurs Inq*, 21(3), 179-191. <https://doi.org/10.1111/nin.12042>
- McInroy, L. B., & Craig, S. L. (2017). Perspectives of LGBTQ emerging adults on the depiction and impact of LGBTQ media representation. *Journal of youth studies*, 20(1), 32-46.
<https://doi.org/10.1080/13676261.2016.1184243>

- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). [https://doi.org/10.1016/S0272-4944\(05\)80231-2](https://doi.org/10.1016/S0272-4944(05)80231-2)
- Mizielińska, J., & Stasińska, A. (2019). Negotiations between possibilities and reality: Reproductive choices of Families of Choice in Poland. *European Journal of Women's Studies*, 135050681988776. <https://doi.org/10.1177/1350506819887765>
- Morris, J., & Feldman, D. (1996). The dimensions, antecedents, and consequences of emotional labor. *Academy of Management. The Academy of Management Review*, 21(4), 986. <https://doi.org/10.2307/259161>
- Morris, M., Cooper, R., Tabatabai, M., Arcury, T., Shinn, M., Im, W., Juarez, P., & Matthews-Juarez, P. (2019). Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: A systematic review. *BMC Medical Education*, 19(1). <https://doi.org/10.1186/s12909-019-1727-3>
- Nath, I. (2018). Inequality, times two: For transgender women, the pay equity gap is even wider. *Maclean's*, 131(2), 28. <https://www.macleans.ca/society/for-transgender-women-the-pay-equity-gap-is-even-wider/>
- National Aboriginal Health Organization. (2012). *Suicide prevention and Two-Spirited People*.
- National Center for Transgender Equality. (2016). *205 US Transgender survey: Executive summary*. <https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf>
- Newman, C. E. (2019). Queer families: valuing stories of adversity, diversity and belonging. *Culture, Health & Sexuality*, 21(3), 352-359. <https://doi.org/10.1080/13691058.2018.1468032>

- Occhino, M., & Skewes, L. (2020). Gatekeepers for gendersex norms: Trans (un)intelligibility and (il)legitimacy within the Danish healthcare system. *NORA: Nordic journal of women's studies*, 28(4), 314-328. <https://doi.org/10.1080/08038740.2020.1834450>
- OK2BEME. (2019). *What does LGBTQ+ mean?* <https://ok2bme.ca/resources/kids-teens/what-does-lgbtq-mean/>
- OUTSaskatoon. (2020a). *Queer terms*. https://www.outsaskatoon.ca/queer_terms
- OUTSaskatoon. (2020b). *Two Spirit*. https://www.outsaskatoon.ca/two_spirit1
- OUTSaskatoon. (2021). Medical professionals. https://www.outsaskatoon.ca/medical_professionals
- Parker-Pope, T. (2009). How hospitals treat same-sex couples. *New York Times*. <https://well.blogs.nytimes.com/2009/05/12/how-hospitals-treat-same-sex-couples/>
- Peart, J., & Mackinnon, K. (2018). Cultivating praxis through Chinn and Kramer's emancipatory knowing. *Advances in Nursing Science*, 41(4), 351. <https://doi.org/10.1097/ANS.000000000000232>
- Philo, G. (1990). Seeing IS believing. *British Journalism Review*, 1(4), 58-64. <https://doi.org/10.1177/095647489000100414>
- Plummer, K. (1984). Sexual diversity: A sociological perspective. In K. Howells (Ed.), *The psychology of sexual diversity* (pp. 219-253). Basil Blackwell Publisher.
- Prasad, A. (2005). Reconsidering the socio-scientific enterprise of sexual difference: The case of Kimberly Nixon. *Canadian Woman Studies*, 24(2-3), 80-84. <https://cws.journals.yorku.ca/index.php/cws/article/view/6121>
- Rainbow Health Ontario. (2014). *Fact Sheet: Reproductive options for trans people*. <https://lgbtqhealth.ca/docs/FactSheet-ReproductiveOptionsForTransPeople.pdf>

- Rau, K. (2019). *Lesbian, gay, bisexual and transgender rights in Canada*
<https://www.thecanadianencyclopedia.ca/en/article/lesbian-gay-bisexual-and-transgender-rights-in-canada>
- reddit. (2016). *Queerception*. <https://www.reddit.com/r/queerception/top/?t=all>
- reddit. (2019). *Seahorse dads*. https://www.reddit.com/r/Seahorse_Dads/
- reddit. (2021). *Reddit by the numbers*. <https://www.redditinc.com/>
- Reed, E. (2018). The heterogeneity of family: Responses to representational invisibility by LGBTQ parents. *Journal of Family Issues*, 39(18), 4204-4225.
<https://doi.org/10.1177/0192513X18810952>
- Richards, L., & Morse, J. M. (2013). *Readme first for a user's guide to qualitative methods* (3rd ed.). Sage Publications.
- Richardson, B., Price, S., & Campbell-Yeo, M. (2019). Redefining perinatal experience: A philosophical exploration of a hypothetical case of gender diversity in labour and birth. *Journal of Clinical Nursing*, 28(3-4), 703-710. <https://doi.org/10.1111/jocn.14521>
- Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., Brown, C., & Eisenberg, M. E. (2019). Perspectives from nurses and physicians on training needs and comfort working with transgender and gender-diverse youth. *Journal of Pediatric Health Care*, 33(4), 379-385. <https://doi.org/10.1016/j.pedhc.2018.11.003>
- Ristock, J., Zoccole, A., Passante, L., & Potskin, J. (2019). Impacts of colonization on Indigenous Two-Spirit/LGBTQ Canadians' experiences of migration, mobility and relationship violence. *Sexualities*, 22(5-6), 767-784.
<https://doi.org/10.1177/1363460716681474>

- RNAO. (2020). *Rainbow nursing interest group*. <https://chapters-igs.rnao.ca/interestgroup/58/about>
- Rooddehghan, Z., Parsayekta, Z., & Nasrabadi, A. N. (2015). Nurses, the oppressed oppressors: A qualitative study. *Global journal of health science*, 7(5), 239.
<https://doi.org/10.5539/gjhs.v7n5p239>
- Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current opinion in endocrinology, diabetes, and obesity*, 23(2), 168-171.
<https://doi.org/10.1097/MED.0000000000000227>
- Savin-Baden, M., & Wimpenny, K. (2014). *A practical guide to arts-related research*. Sense Publishers. <https://brill.com/view/title/36604>
- Scheim, A., Jackson, R., James, L., Sharp Dopler, T., Pyne, J., & R. Bauer, G. (2013). Barriers to well-being for Aboriginal gender-diverse people: results from the Trans PULSE Project in Ontario, Canada. *Ethnicity and Inequalities in Health and Social Care*, 6(4), 108-120.
<https://doi.org/10.1108/EIHSC-08-2013-0010>
- Searle, J., Goldberg, L., Aston, M., & Burrow, S. (2017). Accessing new understandings of trauma-informed care with queer birthing women in a rural context. *Journal of Clinical Nursing*, 26(21-22), 3576-3587. <https://doi.org/10.1111/jocn.13727>
- Sekoni, A. O., Gale, N. K., Manga-Atangana, B., Bhadhuri, A., & Jolly, K. (2017). The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: A mixed-method systematic review. *Journal of the International AIDS Society*, 20(1). <https://doi.org/10.7448/IAS.20.1.21624>

- Sharp, S., McAllister, M., & Broadbent, M. (2018). The tension between person centred and task focused care in an acute surgical setting: A critical ethnography. *Collegian (Royal College of Nursing, Australia)*, 25(1), 11-17.
<https://doi.org/10.1016/j.colegn.2017.02.002>
- Short, E., Riggs, D. W., Perlesz, A., Brown, R., & Kane, G. (2007). *Lesbian, gay, bisexual and transgender (LGBT) parented families: A literature review prepared for the Australian Psychological Society*. <https://www.psychology.org.au/getmedia/47196902-158d-4cbb-86e6-2f3f1c71ffd1/LGBT-families-literature-review.pdf.pdf>
- Smith, C. (2021, April 15). Racism in healthcare: Creating systems change [Panel presentation].
- Snyder, B. K., Burack, G. D., & Petrova, A. (2017). LGBTQ youth's perceptions of primary care. *Clinical pediatrics*, 56(5), 443-450. <https://doi.org/10.1177/0009922816673306>
- Stake, R. E. (1995). *The art of case study research*. Sage Publications.
- Standing Committee on Health. (2019). The health of LGBTQIA2 communities in Canada.
<https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10574595/hesarp28/hesarp28-e.pdf>
- Stanton Lee, K. (2019, January 25). It's easier now for gay men to adopt. But they still face lots of pushback, and weird questions. *Washington Post*.
<https://www.washingtonpost.com/lifestyle/2019/01/25/its-easier-now-gay-men-adopt-they-still-face-lots-pushback-weird-questions/>
- Statistics Canada. (2019). *Sex and Gender*. <https://www12.statcan.gc.ca/census-recensement/2021/road2021-chemin2021/fs-fi/sex-and-gender.cfm>

- Stewart, K., & O'Reilly, P. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Education Today*, 53, 67. <https://doi.org/10.1016/j.nedt.2017.04.008>
- Sutton, D. (2018, August 1). Moneytalk: The LGBT road to family-building. *BNN Bloomberg*. <https://www.bnnbloomberg.ca/the-lgbt-road-to-family-building-1.1116699>
- Tasker, F., & Gato, J. (2020). Gender identity and future thinking about parenthood: A qualitative analysis of focus group data with transgender and non-binary people in the United Kingdom [10.3389/fpsyg.2020.00865]. *Frontiers in Psychology*, 11, 865. <https://www.frontiersin.org/article/10.3389/fpsyg.2020.00865>
- The Annie E. Casey Foundation. (2021). *Social issues that matter to Generation Z*. <https://www.aecf.org/blog/generation-z-social-issues/>
- Tornello, S. L., & Bos, H. (2017). Parenting intentions among transgender individuals. *LGBT Health*, 4(2), 115-120. <https://doi.org/10.1089/lgbt.2016.0153>
- Tornello, S. L., Riskind, R. G., & Babić, A. (2019). Transgender and gender non-binary parents' pathways to parenthood. *Psychology of Sexual Orientation and Gender Diversity*, 6(2), 232-241. <https://doi.org/10.1037/sgd0000323>
- United Church. (2021). *International day against homophobia, transphobia, and biphobia*. <https://united-church.ca/worship-special-days/international-day-against-homophobia-transphobia-and-biphobia>
- Utamsingh, P. D., Richman, L. S., Martin, J. L., Lattanner, M. R., & Chaikind, J. R. (2016). Heteronormativity and practitioner-patient interaction. *Health Communication*, 31(5), 566-574. <https://doi.org/10.1080/10410236.2014.979975>

- van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of sexual behavior*, 44(5), 1177-1213. <https://doi.org/10.1007/s10508-015-0490-8>
- Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, 18(1), 29-39. <https://doi.org/10.1111/j.1440-1800.2011.00539.x>
- Vignoli, D., & Rinesi, F. (2014). Fertility Plans/Intentions. In A. C. Michalos (Ed.), *Encyclopedia of Quality of Life and Well-Being Research* (pp. 2267-2268). Springer. https://doi.org/10.1007/978-94-007-0753-5_1040
- von Doussa, H., Power, J., & Riggs, D. (2015). Imagining parenthood: The possibilities and experiences of parenthood among transgender people. *Culture, Health & Sexuality* 17(9), 1119-1131. <https://doi.org/10.1080/13691058.2015.1042919>
- Waite, S., & Denier, N. (2019). A research note on Canada's LGBT data landscape: Where we are and what the future holds. *Canadian Review of Sociology*, 56, 93-117. <https://doi.org/10.1111/cars.12232>
- Waite, S., Ecker, J., & Ross, L. E. (2019). A systematic review and thematic synthesis of Canada's LGBTQ2S+ employment, labour market and earnings literature. *PLoS ONE*, 14(10), e0223372. <https://doi.org/https://dx.doi.org/10.1371/journal.pone.0223372>
- Wang, Q., Coemans, S., Siegesmund, R., & Hannes, K. (2017). Arts-based methods in socially engaged research practice: A classification framework. *Art/research International*, 2(2), 5. <https://doi.org/10.18432/R26G8P>
- Warner, M. (1991). Introduction: Fear of a queer planet. *Social Text*(29), 3-17. <https://www.jstor.org/stable/466295?seq=1>

- Wechsler, S. (2016, April 23). Reclaiming Two-Spirit health. *Ryerson School of Journalism*.
<https://trc.journalism.ryerson.ca/reclaiming-two-spirit-health-in-toronto/>
- Weigel, D. J. (2008). The concept of family: an analysis of laypeople's views of family. *Journal of Family Issues*, 29(11), 1426. <https://doi.org/10.1177/0192513X08318488>
- Weissman, A. L. (2017). Reproductivity and the reproduction of the Nation-State: The state and sexuality collide. *Journal of GLBT Family Studies*, 13(3), 277-305.
<https://doi.org/10.1080/1550428X.2016.1210065>
- Weitzel, J., Luebke, J., Wesp, L., Graf, M. D. C., Ruiz, A., Dressel, A., & Mkandawire-Valhmu, L. (2020). The role of nurses as allies against racism and discrimination: An analysis of key resistance movements of our time. *ANS. Advances in nursing science*, 43(2), E112.
<https://doi.org/10.1097/ANS.0000000000000290>
- Wingo, E., Ingraham, N., & Roberts, S. C. M. (2018). Reproductive health care priorities and barriers to effective care for LGBTQ people assigned female at birth: A Qualitative Study. *Women's Health Issues*, 28(4), 350-357.
<https://doi.org/doi.org/10.1016/j.whi.2018.03.002>
- Winker, G., & Degele, N. (2011). Intersectionality as multi-level analysis: Dealing with social inequality. *The European Journal of Women's Studies*, 18(1), 51-66.
<https://doi.org/10.1177/1350506810386084>
- World Health Organization. (2021). *Health systems*.
<https://www.who.int/healthsystems/topics/equity/en/>
- World Health Organization. (n.d). What you need to know about Health in All Policies.
https://www.who.int/social_determinants/publications/health-policies-manual/key-messages-en.pdf

World Professional Association for Transgender Health [WPATH]. (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people*, (7th ed.).

https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf

YPulse. (2019). *These Are Gen Z & Millennials' top 15 financial worries right now*.

<https://www.ypulse.com/article/2019/09/10/these-are-gen-z-millennials-top-15-financial-worries-right-now/>

Appendix A – Demographic Form

Date:	Code:
Participant information	
Pronoun(s):	
Age (years):	
Gender:	
Sexual Orientation:	
Relationship status:	
Ethnicity/ethnic identity:	
Level of Education:	
Current occupation/employment:	

Appendix B – Original Interview Guide

Tell me a bit about yourself – where you're from, how long you've been in SK?

What was your interest in participating in this study?

Open-ended questions:

What does 'family' mean to you?

How do you picture your 'ideal family'?

When you think about 'family' what do you envision in the future?

Why do you think you desire _____ as your family?

How do you feel that your family planning needs may differ from someone else's?

What could help you achieve your vision of the family you desire?

Is there anything that gets in the way of you achieving the family you desire?

Do you feel your gender or orientation may influence your idea of how your 'family' looks?

How do you feel your gender or orientation may influence how others see how your 'family' looks?

How do you feel about what is currently out there for 2SLGBTQ folks looking for family planning information?

What has your experience been with family planning?

Tell me about your healthcare experiences related to family planning

Where do you usually find out your health information regarding family planning or to discuss fertility?

Describe what it is like to talk to medical professionals around family planning and your fertility intentions.

What makes a space safe?

What makes a space inclusive?

What would you like to say to healthcare providers/other people about your experience?

Final Question(s):

Is there anything else you would like to add?

Do you have any questions for me?

Have we missed something you think is essential?

Is there anything else you would like to talk about regarding this topic?

Appendix C – Copyright Approval

Adbusters Magazine

Marshall, Kerry

From: Kalle Lasn <kalle@adbusters.org>
Sent: January 24, 2020 1:00 AM
To: Marshall, Kerry
Subject: Re: Permission Request

CAUTION: This email originated from outside of the University of Saskatchewan. Do not click links or open attachments unless you recognize the sender and know the content is safe. If in doubt, please forward suspicious emails to phishing@usask.ca

PERMISSION GRANTED

kalle lasn / editor@adbusters.org
www.adbusters.org

On Jan 23, 2020, at 1:06 PM, Adbusters Media Foundation - Info <info@adbusters.org> wrote:

Please see below.

The Adbusters Team | Adbusters Media Foundation
1243 W 7th Ave
Vancouver, BC
Canada V6H 1B7
Tel: 604-736-9401 | Our staff answer calls Monday to Friday, 11 am to 5 pm PST

----- Forwarded message -----

From: Marshall, Kerry <kmm734@mail.usask.ca>
Date: Tue, Jan 21, 2020 at 4:49 PM
Subject: Permission Request
To: info@adbusters.org <info@adbusters.org>

Hi there,

I am a Master's of Nursing student at the University of Saskatchewan working towards completion of a thesis based on the experience of individuals within the 2SLGBTQ community regarding family planning and fertility intentions. I am incorporating arts-based research through including 6-10 participants in collage creation related to the above topic, and I am hopeful we could utilize content from your magazine. The thesis would be published in HARVEST (the UofS open access repository). Arts-based research has a component of making results more accessible to the greater public that may not be privileged to most research articles/information/databases. Because of this, a part of knowledge translation could include presentations to different organizations, or at conferences, and the presentations may include sharing of created collages – however, it is unconfirmed at this time. All use would be noncommercial.

An (amazing) independent book store in Saskatoon - Turning the Tide - has past copies of the magazine they would be I am curious around the process and feasibility of this and am thankful in advance for your time.

I can be reached here via email or phone at 403-993-2650.

Thank you again!

- Kerry

Shameless Magazine

Friday, October 2, 2020 at 17:33:24 Central Standard Time

Subject: Re: Copyright permission question
Date: Sunday, February 23, 2020 at 11:45:33 AM Central Standard Time
From: Sheila Sampath
To: Marshall, Kerry

CAUTION: This email originated from outside of the University of Saskatchewan. Do not click links or open attachments unless you recognize the sender and know the content is safe. If in doubt, please forward suspicious emails to phishing@usask.ca

This is fine! Thanks for asking, Kerry.

--

Sheila Sampath
Editorial and Art Director, Shameless Magazine
[P.O. Box 68548](mailto:P.O.Box.68548@usask.ca), Walmer
Toronto, ON M5S 3C9 CANADA
www.shamelessmag.com

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On Feb 21, 2020, at 10:43 PM, Marshall, Kerry <kmm734@mail.usask.ca> wrote:

Hi there,

I am a Master's of Nursing student at the University of Saskatchewan, working towards completion of a thesis based on the experience of individuals within the 2SLGBTQ community regarding family planning and fertility intentions. I am incorporating arts-based research through including 6-10 participants in collage creation related to the above topic, and I am hopeful we could utilize content from your magazine. The thesis would be published in HARVEST (the UofS open access repository). Arts-based research has a component of making results more accessible to the greater public that may not be privileged to most research articles/information/databases. Because of this, a part of knowledge translation could include presentations to different organizations, or at conferences, and the presentations may include sharing of created collages – however, it is unconfirmed at this time. All use would be noncommercial.

An (amazing) independent book store in Saskatoon - Turning the Tide – recommended that I reach out to Shameless magazine & has past copies they would be willing to donate to the project if permission is granted.

I am curious around the process and feasibility of this and am thankful in advance for your time. I can be reached here via email or phone at 403-993-2650.

Thank you again!

- Kerry

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